

**Nutrition and Health:  
A Comprehensive Assessment of Programmes for  
Women and Children in Two Districts of Karnataka**

*In collaboration with*

**Department of Social Welfare, Government of Karnataka  
Department of Health and Family Welfare, Government of Karnataka  
Department of Education, Government of Karnataka**

*Sponsored by*

**Karnataka State Council for Science and Technology, Bangalore**

*February, 1991*



**INDIAN SOCIETY OF HEALTH ADMINISTRATORS (ISHA)**

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## PREFACE

The Constitution of India, as a Directive Principle of State Policy, provides that the "State shall regard the raising of level of nutrition and standard of living of its people, and the improvement of public health as among its primary duties (Article 47). Specifically, the Constitution authorises the Central and State Governments to undertake programmes for improvement of health and nutritional status of women and children.

The Indian Society of Health Administrators has been concerned with health of the high risk groups, particularly women and children. Two of the ISHA annual Conferences were organized on this theme, namely, the 1987 Conference on "Health of the High Risk Groups: Mothers, Children, and Elderly", and "Health of Women and Children for Development". At both Conferences and also at several forums, the critical need for a concerted thrust to women and children's programmes was emphasized, as well as the need for a coordinated multisectoral effort, to raise the level of health and nutritional status of these groups.

In keeping with its commitment, the Government of India has initiated six major programmes for health and nutritional status improvement of women and children, namely, the ICDS programme, and the Special Nutrition Programme (Dept of Women and Children's Welfare), the Immunization Programme, Vitamin A administration against Nutritional Blindness and Prophylaxis against Nutritional Anemia (Department of Health and Family Welfare) and the School Mid-day Meal Programme (Department of Education). Several schemes have been also launched for socioeconomic development of women and children. For effective utilization of resources towards equitable achievement of the goals of health and nutritional development, it is essential to make an assessment of outreach and impact of these programmes, and particularly in the backward districts and subpopulations.

The Karnataka State Council for Science and Technology (KSCST) is an apex institution in the State concerned with promoting action-oriented science and technology research so as to improve the quality of life and systems. In line with these objectives, ISHA approached the KSCST to make a comprehensive study of health and nutritional development programmes for women and children being implemented by different Departments in Karna-







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taka State. It was decided that, to begin with, the two backward districts of Hyderabad-Karnataka area, namely, Gulbarga and Raichur districts, should be taken up for study to be followed subsequently, by the State-wide Study.

This Report is based on data collected at the State level from the Departments of Women and Children's Welfare, Health and Family Welfare, and Education; at the district level from the two districts of Gulbarga and Raichur, at the taluk level from five selected taluks and at the village, school and household levels.

The Study Team consisted of the following members.

1. Dr Ashok Sahni, Professor and Hony Executive Director
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We are extremely grateful to the Department of Social Welfare (Shri S P Singh, Former Commissioner and Secretary, Government of Karnataka; Smt Meera Saxena, Director, Women and Children's Welfare; Shri M Umesh, Deputy Secretary; Shri P S Vastrad, Joint Director) for their support and encouragement in facilitating the data collection and visits of the Study Team. We are particularly grateful to the officers and functionaries of the Department in Gulbarga and Raichur Districts for their efforts to facilitate collection of data by the Study Team. We are also grateful to Dr T R Ranganathachar, Director of Health and Family Welfare, Government of Karnataka, Dr Galagali, Joint Director (MCH) and Smt Jalaja Sundaram, Deputy Director (Nutrition); Shri M L Chandrakeerthi, Commissioner and Secretary, Department of Education, Shri B N Raghavendrachar, Joint Director (Mid-day Meals), and Shri Muniswamappa Senior Assistant Director (Education) for their discussions, support and facilitation of data collection from the districts.







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The State level information was collected during October-November 1990, and the field data from the Districts, during November-December, 1990.

We are extremely thankful to KSCST for sponsoring this Study, particularly to Dr B R Pai, Honorary Secretary, and Shri S Rajagopalan, Executive Secretary. We are also thankful to Dr B R Pai, and Shri Ravi Honnavar for visiting the field to help coordinate the data collection.

ISHA hopes that this study will assist the Departments of Women and Children's Welfare, Health and Family Welfare, and Education, towards more effective implementation of the programmes for health and development of women and children particularly in the backward districts of Karnataka State.

February 1, 1991

Dr Ashok Sahni  
Professor and  
Hony Executive Director







## ACKNOWLEDGEMENTS

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| 32.                      | Smt Sumitra, Anganwadi Worker, Karajgi, Gulbarga Dist                       |   |   |
| 33.                      | Smt Hirabai, Anganwadi Worker, Tengli, Gulbarga Dist                        |   |   |
| 34.                      | Smt Thulajamma, Anganwadi Worker, Batgera-K, Gulbarga Dist                  |   |   |
| 35.                      | Smt Parvathi, Anganwadi Worker, Mullkod, Gulbarga Dist                      |   |   |
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38. Smt Indiramma, Anganwadi Worker, Jalibenchhi, Raichur Dist
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## SUMMARY AND RECOMMENDATIONS

### I. SUMMARY

1. Towards promoting health and nutritional development of women and children, National level and State sector Programmes have been initiated and implemented by the Government of Karnataka. The six major programmes being implemented are: i) The Integrated Child Development Services Programme and, (ii) Special Nutrition Programme, being implemented by the Department of Women and Children's Welfare; (iii) Immunization Programme, (iv) Vitamin A administration against nutritional blindness in children, and (v) Prophylaxis against Nutritional Anemia in Children and Mothers, by the Department of Health and Family Welfare; (vi) The School Mid-day Meal Programme by the Department of Education. In addition, four major schemes are being implemented for socioeconomic development of women by the Department of Women and Children's Welfare, which would indirectly influence their health and nutritional status. These include two schemes with Central Government Assistance, namely, the scheme of financial assistance to promote Mahila Mandals in rural areas and scheme of financial assistance to voluntary organizations to run Creches for children of agricultural labourers in rural areas. The two schemes initiated by the State Government of Karnataka are, the Maternity Allowance Scheme to Agricultural Landless Women Labourers, and the Subsidy Scheme for Income Generating Activities by women (Grihakalyana Scheme).

2. The objectives of this study were to understand the present status of implementation of these programme in the State, and particularly in the two backward districts of Hyderabad-Karnataka area, viz. Gulbarga and Raichur Districts; and, to assess the impact being made on the overall health and nutritional status of women and children in the two study districts, by these programmes being carried out by different Departments. Based on the observations, recommendations were to be made towards more effective implementation of the programmes.

3. The study methodology included, collection of data at the State, and District levels from the Programme Officers of the Departments of Women and Children's Welfare, Health and Family Welfare and, Education; collection of data from the Project/taluk level; and, from the anganwadi (village), and school level. A sample of beneficiary families in the villages were interviewed; a sample of children attending the anganwadis and primary school children attending class I - IV were assessed, for health and nutritional status. Voluntary agencies active in the two districts were visited and studied for their role and contributions.







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4. The data collected pertained to, present status of implementation - resources analysis (finance and infrastructure); organizational structure for implementation; coordination, supervision, monitoring and control; involvement of the voluntary agencies; beneficiary utilization and perceptions of the services; impact on health and nutritional status of children.

5. In the study districts, three of eight ICDS Projects (taluks) in Gulbarga district and two of four Projects in Raichur district were selected at random, for detailed study. In each taluk, one frequently supervised anganwadi centre and one infrequently supervised anganwadi centre (AWC) was selected to give a total of 10 AWCs. Schools in the neighbourhood of the selected AWCs were selected for study to include balanced number of mid-day meal schools and non mid-day meal schools. The study observations are based on data at the State level and at the district level from Gulbarga and Raichur districts; Project/taluk level data from five taluks, and from ten AWCs, four schools with Mid-day Meal Programmes and four without; interviews of 175 ICDS beneficiary families from the nine selected villages; nutritional and health assessment of 217 children below six years of age, and 338 school children.

## II. CONCLUSIONS

### A. Integrated Child Development Services Programme

6. Among the programmes, the ICDS Programme is of critical importance since it aims to improve the nutritional status and overall development of children in the most critical period of life. At the State level, all indicators of Programme implementation showed high degree of commitment of the State Government to achieve the objectives of the Programme, and particularly to cover the most needy areas. This commitment was reflected in the satisfactory expansion of the ICDS Programme in the State from year to year (60% taluks covered by 1989-90 and 74% to be covered by 1990-91); pattern of coverage to include the most needy drought-prone taluks; adequate budgetary provision from year to year for supplementary nutrition component as well as for administration; satisfactory budgetary allocations for training and completion of training of all categories of personnel. Other critical factors which are indicative of successful Programme Implementation are, adequate number of trained anganwadi workers (AWWs) in position; high coverage of targetted children of three to six years age group; and successful utilization of services of the voluntary agencies for providing satisfactory training to anganwadi workers. The impact of ICDS on nutritional status of children in the State appeared favourable in majority of the Projects, as observed from State level data and the most marked improvement appeared to have been achieved in the districts of Mysore Division.







7. The major areas of constraint and issues of concern at the State level related to, a few very needy drought-prone taluks (e.g. Molakalmuru taluk of Chitradurga district, many taluks of Dharwar district) were not yet covered by ICDS in spite of 14 years of operation of ICDS in the State; limitation of population coverage in the State Sector ICDS Projects due to financial constraints; relatively low coverage/beneficiary utilization of children below three years as well as pregnant and lactating mothers for supplementary nutrition; inadequate expenditure (in spite of adequate allocation) on Supplementary food per beneficiary; high post vacancy position of Child Development Project Officers and anganwadi supervisors who are the key to the success of the Programme; and, apparent coordination difficulties with the Department of Health and Family Welfare to ensure periodic health checkup and nutritional rehabilitation of anganwadi children, and to ensure coverages for the Vitamin A administration Programme and the Anemia Prophylaxis Programme.

8. In the two Study districts, overall, all indicators were that the ICDS Programme, particularly the supplementary nutrition component was being commendably kept up in the face of serious constraints. Eight of the ten taluks in Gulbarga district have established ICDS Projects of which two are State Sector Projects; the remaining two taluks would be implemented under the ICDS by 1990-91; four out of nine taluks in Raichur district (the unirrigated backward taluks) have established ICDS Projects of which one is a State ICDS Project, two more taluks are due to be implemented under ICDS by 1990-91.

9. The favourable aspects of ICDS Programme implementation in the two districts were as follows: Satisfactory coverage of child beneficiaries particularly in the Central ICDS Projects of Gulbarga district; adequate number of trained anganwadi workers in position; about 80% of the anganwadi workers belonging to the village of work in Gulbarga district (except in case of Chittapur taluk); maintenance of feeding programme in spite of constraints; and, high degree of beneficiary appreciation of the services and awareness of the importance of the preschool education component of ICDS.

10. The impact study on nutritional status of children below six years showed a significant improvement in ICDS Projects which were more than three years in operation compared with the children in the recently started Projects. Male and female children in the ICDS Projects showed similar nutritional status. (Narrowing of male/female nutritional status differentials is one of the objectives of the ICDS). The study of the role of frequency of anganwadi supervision in improvement of nutritional status showed that children of the more frequently supervised anganwadis had significantly lower rates of severe PEM (as shown by hair signs) as compared with the infrequently supervised group. However, the overall rates of severe malnutrition were still very high even in the long established Projects, which was







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attributed to large scale migration for employment.

11. The system of having honorary anganwadi workers appeared to be a major asset to the Programme with high degree of accountability being established on the part of the AWW to the community as well as the ICDS administration.

12. The major constraints and issues in the ICDS Programme in the two Districts related to the following: chronic low post occupancy of posts of Assistant Directors, CDPOs, and particularly anganwadi supervisors (70% posts of supervisors vacant in Gulbarga and 40% in Raichur), unduly low coverage of eligible population in the State sector Projects of Chittapur, Jewargi and Yelburga due to financial constraints; administrative constraints and consequent interruption of the feeding programme due to the practice of routing all routine budgetary funds and sanctions through the Zilla Parishads; very low literacy and awareness of the community to demand services in quantity and quality; relatively low coverage of scheduled caste and scheduled tribe in proportion to the need; unsatisfactory educational qualification of many anganwadi workers (below S S L C)- about 40% in both districts, resulting in suboptimal performance of AWCs; unsatisfactory qualification of many promotee anganwadi supervisors (less than graduates) resulting in difficulties of proper anganwadi supervision; poor roads, long distances, poor bus transport services, and poor accessibility of about 30-40% anganwadis for about six months of the year due to rains, resulting in further erosion of efficiency of supervision; difficulties of food transportation due to the above factors; lack of buildings for about 50% of anganwadis, resulting in scope for misuse of food items; low community participation in the programme; inadequate frequency of visits of Medical Officers to the anganwadis; high seasonal migration of farm labourers, resulting in vulnerability of these children to severe malnutrition.

### B. Immunization Programme

13. The Immunization Programme in Karnataka started with the Expanded Programme of Immunization in 1978 to provide immunization to children against the five major killer diseases of childhood, and to pregnant mothers against tetanus, through the existing health services. The programme was intensified since 1985, by taking up Universal Immunization Programme in a phased manner in the districts towards ensuring almost total coverage of every mother and child, and it was further strengthened in 1989 with managerial inputs under the Technology Mission, to ensure coverage within a time schedule.

14. The State level data on performance under immunization showed that, the performance which was found to be low by Vaccination Surveys prior to UIP introduction, rapidly gained momentum in most of the districts once UIP was introduced, to reach out to about 75-80% of







infants on schedule, as shown by Evaluation Surveys. This improvement was slightly tardy in case of measles, BCG and antenatal tetanus toxoid. Performance statistics from the districts suggested that the ICDS taluks performed better in the immunization programme after introduction of UIP in the districts, suggesting good mobilization of ICDS manpower for the programme under UIP. The declining trends in incidence of vaccine preventable diseases in most of the districts of the State as shown by surveys, confirmed the improved immunization performance of most districts (other than those of Gulbarga division) following introduction of UIP. Sample testing of potency of vaccines from the field had showed high potency of most samples from most of the districts.

15. In the districts of Gulbarga and Raichur the following salient features were apparent: Gulbarga district vaccination coverage had remained low (below 50%) during 1989 despite introduction of UIP in 1986-87. In Raichur, UIP was introduced in 1987-88. During 1988 vaccination coverage found during a survey was about 30%. However during the current year, 1990-91, all indications were that coverage had improved in both districts. The beneficiary survey conducted by the study team showed that there was good coverage of about 80% for DPT and polio vaccines in the ICDS taluks of two districts, slightly lower for measles and BCG vaccines (61% and 72% respectively), but very low coverage of pregnant mothers (25%). High degree of involvement of the ICDS functionaries and officers at all levels in the immunization drive was evident.

16. The major constraints and issues in the immunization programme in the two study districts related to, high post vacancy of medical officers, very high post vacancy of supervisory cadres and health workers. Infrastructure for cold chain maintenance was adequate, as well as, adequate resources for mobility of personnel for the immunization drive were being mobilized from several sources including the ICDS programme.

#### C. Vitamin A Administration Against Nutritional Blindness

17. Under this programme Vitamin A is administered to children of one to five years of age twice a year. Adequate supplies to cover a total of about 31 lakh child population of this age group in the State, were being procured from the Government of India twice a year and distributed to the health institutions. Performance statistics show high degree of coverage in all districts. The beneficiary survey in ICDS taluks in the two study districts showed that 31% of 368 children of this age group had received Vitamin A supplementation.

#### D. Prophylaxis Against Nutritional Anemia in Mothers and Children

18. Under this programme, tablets of iron and folic acid (100 tablets







in two installments) are distributed to pregnant mothers at the time of antenatal check up, to be consumed over a period of 100 days. Similarly 100 smaller tablets are given to mothers for administration to children below six years of age. The performance statistics at the State level showed high coverage under this programme (more than 100% achievement of targets), in case of mother beneficiaries and about 50% in respect of child beneficiaries. Gulbarga and Raichur districts reported 86% and 65.5% coverage respectively for mother beneficiaries, and, 41.5% and 25.4% for child beneficiaries. The beneficiary family survey in this study showed 25% coverage of mother beneficiaries (closely parallel with the tetanus toxoid coverage of the mothers), and 4% coverage of child beneficiaries.

19. Overall, in respect of the Health Programmes, the major programme which was making commendable progress was the Immunization Programme, particularly in respect of children. Relative to this programme, the Vitamin A administration and nutritional anemia prophylaxis programmes appeared to be receiving less priority at the field level.

#### E. Special Nutrition Programme

20. The Special Nutrition Programme aims to improve nutritional status of children under five years, as well as pregnant and lactating mothers in urban slums and tribal areas through provision of supplementary nutrition, through food distribution centres. With expansion of the ICDS programme, the SNP centres are being converted to ICDS centres and thus SNP is being gradually wound up. About 1,72,824 beneficiaries in urban Karnataka were being served under SNP in 1989-90.

#### F. School Mid-day Meal Programme

21. The School Midday Meal Programme was started in 1963-64 towards improving school enrollment, improvement of literacy and nutritional status of children, with CARE assistance. Currently, being run by the State Government with partial assistance from CARE, the programme covers about 32% of primary school children in the State. The assessment of impact of the programme in the two study districts showed a positive influence of the programme on nutritional status, particularly in terms of preventing stunting of growth, and prevention of serious Vitamin A deficiency in school children assessed. The programme was also probably contributing to promotion of literacy through better retention of primary school children from Class I to Class IV as indirectly indicated by the Class IV:Class I ratios in the schools with and without midday meal programme. The programme was also appreciated by students as well as teachers.







22. The major constraints and issues in the mid-day meal programme related to very low provision of budget per beneficiary for supplementary items and transportation under CARE programme (at prices fixed almost 20 years or more ago), and progressive decrease in the number of feeding days per year.

**G. Subsidy Scheme for Income Generation Activities (Grihakalyana Scheme)**

23. Under this scheme, on an average, every year about 4-5 women of the economically weaker sections in each ICDS taluk of the State are provided with a subsidy of 25% of the total investment, together with a low interest bank loan of 75% of investment to start small income generating units in the taluk towns. The positive features of the programme included, by and large successful utilization of the funds by beneficiaries for income generation purpose, as evidenced by loan repayments.

24. The major constraints related to, insufficient amount allowed as subsidy and loan to take up skills oriented units; provision for very limited coverage (only for about 4-5 women per taluk per year); and procedural constraints, delay and nonutilization of funds on account of routing all funds through Zilla Parishads.

**H. Maternity Allowance for Agricultural Landless Labourers**

25. Under this scheme, agricultural women labourers are provided an allowance of Rs.300/- at the time of their first two deliveries, towards promotion of nutrition and rest during late pregnancy and lactation. The beneficiary survey in the ICDS taluks of the districts showed that mostly the beneficiaries belonged to the poor socio-economic groups and the benefit had been given for the first two deliveries only. The major constraints related to the following: None of the beneficiaries adopted family planning or child spacing method, resulting in continued high risk of maternal ill-health subsequently, few mothers to get the allowance processed.

**I. Creaches for Children of Agricultural Labourers in Rural Areas**

26. Financial assistance is provided to voluntary organizations for running creches in villages. It was reported that many of the 200 or so creches in the State being financially assisted, frequently did not conform to requirements.

**J. Mahila Mandal Scheme**

27. Under this scheme financial assistance is provided to encourage women's development activities by Mahila Mandals. Observations in the two districts suggested that this scheme was better established in the







ICDS taluks under the guidance of the ICDS functionaries, and not much headway had been achieved in other taluks. Observations in Afzalpur taluk and Deodurg taluk also suggested that the scheme has high potential promoting women's development activities and for promoting community participation in the programmes if properly mobilized.

#### K. Role of Voluntary Agencies in Promotion of Health and Nutrition of Women and Children

28. State level data on voluntary organizations assisted by the Government showed that several voluntary agencies were being involved, but mostly in districts other than the two study districts. Major involvement of the voluntary agencies was evident in respect of angan wadi workers training (needs of the State fully met by voluntary agencies), women's training centres, starting of hostels in urban areas for working women, creches (run by Mahila Mandals) in rural areas. In Gulbarga district no other major voluntary organization other than Anganwadi Training Centre and Family Planning Association of India could be identified. FPAI in Gulbarga and Raichur was promoting acceptability of family planning : 'Samuha' a voluntary organization in Deodurg taluk of Raichur district had contributed greatly through innovative training of AWWs, to deliver better services, as also through promotion of Mahila Mandals in the taluk.

### III. RECOMMENDATIONS

Keeping in view the study findings, the following recommendations are made for more effective utilization of resources for achieving programme objectives.

#### A. Integrated Child Development Services Programme

29. Towards resolving the major constraints and issues in the ICDS programme, the following actions are recommended.

(i) At the State level, to improve ICDS coverage to the most needy population, it is recommended that very backward, drought-prone or high SC/ST populated taluks, which are yet to be covered by ICDS, could be identified and brought under ICDS on a priority basis.

(ii) In view of limited financial resources in the State Sector Projects, the ICDS objectives would be better served if State Sector Projects in backward drought prone taluks are speedily converted to Central Sector Projects on a priority basis.

(iii) Another major constraint related to paucity of officers and supervisory staff due to indiscriminate ban on recruitment, coupled with steady increase in the number of ICDS projects year after year. Keeping in view the critical role of these key staff, it is recommend-







ed that recruitment of all categories of Programme Personnel (field staff) responsible for Programme implementation should be outside the scope of the recruitment ban. In particular, since the liability of staff costs of ICDS Programme is borne by the Central Government, adequate staff should be recruited and posted, so that huge resources being anyway spent on supplementary nutrition component, could be efficiently utilized.

iv) Owing to the critical role of CDPOs and supervisors during the first two to three years of a newly sanctioned ICDS Project, it is suggested that these key posts should be filled in newly sanctioned Projects to enable them to lay a sound foundation for subsequent success of the Project.

v) Keeping in view the chronic low post occupancy in Gulbarga division, innovative personnel policies are required to motivate staff to serve in such areas. Financial incentives such as difficult area allowance, additional increments and/or weightage for promotion for long years of active service in these districts, could be suitably evolved.

vi) To overcome the problem of Programme interruption due to delays in sanction of funds, it is recommended that routine budgetary expenditure on items such as supplementary nutrition, which are not discretionary but provided for according to fixed norms, could be directly released to the District Officers without routing through the Zilla Parishads. However, an alternative system of ensuring feedback and positive influence of the Zilla Parishads on the ICDS functioning could be devised.

vii) Keeping in view the resource constraints, a major thrust to develop community participation in the ICDS programme is required, so that eventually, local resources would augment Government resources to improve the quality of supplementary nutrition, as well as quality of services. Towards developing a systematic strategy for community participation, the following action plans are suggested:

a) The existing Anganwadi Training Centres which are voluntary organizations providing satisfactory training to AWWs, could be mobilized to design and conduct training programmes for AWWs and supervisors in drawing community participation. For this, the resources could be made available to augment the existing infrastructure and salaries of staff.

b) Training Programmes in community participation could be organized through government and voluntary organizations for CDPOs and senior officers of the Department.







c) Indicators of community participation could be developed by the Department and regularly monitored at the State, District and Project levels, to ensure continuing effort and commitment by the field staff to this approach.

viii) In view of resource limitations to keep up with a fast growing population, the AWWs could be actively involved in promoting acceptance of the small family norm. For this, the AWWs could be trained as part of the comprehensive training for developing skills of community participation.

ix) Towards improving the service delivery and better utilization of services by vulnerable subgroups of beneficiaries, namely children below three years and pregnant mothers, the following strategies are suggested:

a) The anganwadi helper could keep the anganwadi open after 1:00 PM to look after the children below three years till about 4:30 or 5:00 PM when mothers return from the field. For this the anganwadi helper could be paid additional honorarium, as also the anganwadi worker. This step would also indirectly aid in school enrollment of children above six years of age who frequently discontinue schooling to look after younger siblings in the absence of parents.

b) The anganwadi helper could prepare and distribute the food supplement to pregnant and lactating mothers once more at closing time around 4:30 PM, when these mothers would have returned from the fields. This would also help in nutritional rehabilitation of the severely malnourished children who require frequent small feeds.

c) The CDPOs, Supervisors, and Anganwadi Workers, could be oriented to the desirable child nutrition, health, sanitation and personal hygiene practices for prevention of sickness and health promotion. Monitoring of health education provided by AWWs, by the supervisors could be made an intrinsic part of supervision by the supervisors and CDPOs, just as they crosscheck stocks of food items.

d) The content of health education should be worked out by the CDPO supervisors and AWWs keeping in view the local availability of nutritious low cost foods, as well as local cooking and child feeding practices.

x) To overcome difficulties in intersectoral coordination, which is crucial for nutritional improvement and rehabilitation of severely undernourished children, for improving coverage in the Vitamin A administration, and Anemia Prophylaxis Programme, the following strategies are suggested:







a) At State level, periodic joint meetings of District level officers of the Women and Children's Welfare Department and Health Department could be conducted under the joint State level leadership of both Departments to review the status of intersectoral coordination and to work out strategies to improve the same.

b) Indicators of intersectoral coordination in the different Programmes could be developed and monitored at State, District and Taluk levels, on a regular basis.

xi) Towards overcoming the constraints in service delivery specifically in Gulbarga and Raichur districts, the following measures are suggested:

a) AWWs with less than SSLC qualification could be deputed for special training programme with individualized attention to enable them to perform efficiently.

b) Promotee anganwadi supervisors with less than graduate qualification could also be deputed for special training programmes to bring up their competencies in supervision and guidance.

c) Personnel policies for promotion to supervisors posts may need a review, and suitable requirements of eligibility could be laid down in case of non-graduate candidates, such as fixing an age limit, so as to improve the quality of personnel manning these posts.

d) Specific emphasis by CDPOs and supervisors is required regarding growth monitoring of children who are not enrolled for supplementary nutrition.

e) To overcome the constraints on quality of ICDS services and of supervision due to a combination of, inadequately qualified AWWs and supervisors, bad roads, remote villages and sparse population, and inadequate bus services, an interim measure could be considered, namely, to post supervisors in such districts based on the norms of tribal areas, namely one Supervisor for 15 AWCs.

f) In Gulbarga and Raichur districts, keeping in view the high seasonal migration rates, and the high vulnerability of these children to severe malnutrition, it is suggested that in ICDS Projects of the irrigated taluks of these districts (to which workers migrate), higher targets of beneficiaries could be permitted to include children of migrant workers to avail the nutrition, in the seasons of migration. Specific strategies of implementation and monitoring would need to be worked out to operationalize this concept.







g) Keeping in view the recurring problem of securing transport arrangements for food stuffs in these two districts, it is suggested that provision of an additional vehicle exclusively for making supplies to the AWCs could be considered, until the roads and transportation infrastructure in these districts improve.

### Health Programmes

29. Towards resolving the constraints of staff in the two study districts for achievement of the health programmes, innovative personnel policies are required to offer financial and career incentives to doctors and health professionals who put in several years of service in these difficult areas.

30. The situation of inadequate coverage of the eligible child population for coverage under Vitamin A administration and anemia prophylaxis, would benefit greatly from an appropriate strategy of intersectoral coordination with the functionaries of the Department of Women and Children's Welfare, as illustrated by the achievements of immunization programme under UIP. It is suggested that a detailed strategy could be worked out to ensure continuing coordination from the village level onwards.

31. In order to supplement the Vitamin Prophylaxis Programme for prevention of nutritional blindness, an intersectoral scheme could be implemented involving the ICDS functionaries, Health Department functionaries, Forestry Department and Agriculture Department to promote the kitchen garden concept in the villages involving drought resistant leafy vegetables and fruit trees. This would reduce the dependency of the community on the Vitamin A Programme, as also reduce the incidence of serious Vitamin A deficiency in older children who are not eligible for Vitamin A administration.

### School Mid-day Meal Programme

32. Keeping in view the observations regarding the School Mid-day Meal Programme, it is recommended that a detailed State-wide Evaluation Study be undertaken, to corroborate the findings of the present small scale study relating to impact on nutritional status and continuation of primary school education by school children., The findings of such a study could profoundly influence the future directions of the School Mid-day Meal Programme in the State.

33. Keeping in view the impact on nutritional status and potentials of the Mid-day Meal Programme to contribute to achievement of the national goal of universal literacy, the following suggestions are made towards more effective implementation of the Programme:







- a) The limited financial resources and CARE assistance available under the School Mid-day Meal Programme would serve the objectives of the Programme better, if they are concentrated in districts/taluks/pockets with greater need i.e. backward, low literacy or high prevalence of child malnutrition.
- b) Under the CARE Programme, the acceptability of the programme to teachers and students as well as financial viability for implementation would be enhanced greatly, if the allocation per beneficiary is stepped up substantially to provide for the required fuel, vegetables and condiments, and honorarium to a local cook or helper.
- c) Keeping in view the limitation of resources, at some stage community participation will be vital for continuation of the programme to provide additional items such as locally grown vegetables and condiments. It is recommended that a detailed action Programme be worked out to systematically train the teachers involved, in the community participation approach. For this the Education Department could consider utilizing the services of the existing Anganwadi Training Centres, and other voluntary organizations. These training programmes could be organized for the AWWs of the ICDS, School teachers and anganwadi supervisors jointly, to enable them to work together subsequently in the field for community participation.
- d) Specifically in Gulbarga and Raichur districts, it was observed that the bulgar wheat was very coarse and possibly unacceptable to some extent. It could be processed further to promote acceptability and palatability to students.

#### Socioeconomic Programmes for Women

34. Towards resolving the major constraints and issues in the Scheme of Maternity Allowance to Agricultural Women labourers, it is suggested that, to ensure that it becomes a long term investment in mother and child health, the allowance should be linked to acceptance of either terminal method of family planning or child spacing method, namely IUD. It also suggested that to ensure that the Programme indeed reaches the poorest sections of the society, the ICDS functionaries should be involved in identification of the beneficiaries.

35. In the Subsidy Scheme for Income Generation Activities by Women, to address the major constraints and issues as well as to improve its impact, the following suggestions are made:

- a) Allocations could be increased under this scheme so that an average of atleast about 40-50 women per taluk could be assisted every year which is considered to be within the ability of the present ICDS infrastructure to handle.







b) Links could be established with the Women's Vocational Training centres being assisted by the Department of Women and Social Welfare, and the District Industries Centre, so that women trained in vocational skills can be financially assisted.

c) Keeping in view the reluctance of the banks to become involved in small financing schemes, the Karnataka Women's Development Corporation needs to be made operational to undertake the Programmes of Women's Development in a big way.

d) The subsidy limit as well as loan component limit need to be raised, so that more enterprises involving skills and value added production could be started.

36. Under the Mahila Mandal Scheme, it is suggested that a major thrust should be given to the Mahila Mandal Scheme by training the ICDS functionaries in promoting Mahila Mandal formation and women's development activities. In fact Mahila Mandals have immense potential to be the hub of community participation in mother and child health, family welfare, literacy, creche scheme, and other programmes.

#### IV FUTURE RESEARCH

37. The study has brought into focus many issues and observations of critical importance to the success of the Programmes in achieving the objectives. However, since the study is limited to two districts, it is difficult to prioritize the major issues at a State level, since major issues and observations in the two Study districts of Gulbarga and Raichur may differ widely from those in other divisions. In view of this, the study would need to be carried out in a State-wide basis, on all Divisions so that, while issues of district or divisional importance would not be lost sight of, the major issues at State level would be identified, towards developing strategies for improving the implementation of the respective programmes.

38. In the case of the School Mid-day Meal Programme, keeping in view the many issues raised in the study of two districts, a State-wide Evaluation Study to assess the impact, is essential to verify the observations of this study, which can provide further directions to the Programme.







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## Chapter - I

### HEALTH AND NUTRITION PROGRAMMES FOR WOMEN AND CHILDREN IN KARNATAKA STATE

*This Chapter reviews the evolution of maternal and child health programmes in India, and provides a brief description of the six major programmes currently in operation in Karnataka State, for health and nutritional development of women and children. Each Programme is described with regard to its objectives, scope of activities and infrastructure for implementation, along with a brief overview of its present status at the National level. In addition, a brief note is included on socio-economic Programmes currently in progress in Karnataka for women, which indirectly influence women's health status.*

#### A. EVOLUTION OF THE PROGRAMMES

1. Women and children constitute a major vulnerable section of the population. In the 1981 Census, in Karnataka, children under 15 years constituted 42% of the total population, and together with women in the child-bearing age group (15-49 years of age), they constituted 62.7% or nearly two thirds of the total population. The quality of human resources of the country, both at present and in future, depends upon the health of women and their resultant performance in their physical, social, cultural and emotional role as mothers. The quality of future citizens also depends upon the present health status of growing children, which in turn depends on antenatal nutrition of the foetus through adequate maternal nutrition), birth weight of the infant, under-five child's nutritional status, as well as the socio-cultural environment.

2. Keeping in view these critical aspects of child health, the Government of India has been authorised by the Constitution of India to undertake specific programmes for improvement of health, nutritional status and overall development of women and children (1). In 1959, India became a signatory to the UN Declaration of the Rights of the Child. Principle-4 of the Charter states: "The child shall enjoy the benefits of social security. He shall be entitled to grow and develop in health; to this end, special care shall be provided to him and the mother including adequate prenatal and postnatal care". In keeping with this commitment, the Government of India launched several nation-







al programmes, beginning with the Mid-day Meal Programme for preschool children and children attending the primary schools in 1963-64.

3. The ICMR National Nutrition Survey of 1965 and several other survey findings suggested high prevalence of undernutrition in mothers and children (2) and as a result, in 1970-71, the Special Nutrition Programme was initiated to provide a food supplement with high quality protein to pregnant and lactating mothers as well as to underfive aged children. Around the same time, the Government of India formulated the National Child Policy in 1974, which emphasized the commitment and priority given by the Government to child development in the country's total developmental efforts (4). By this time the preliminary observations and studies of the Special Nutrition Programme suggested that, while the Programme was certainly beneficial, there was need for an organized comprehensive child development programme which should be systematically implemented all over the country. Under the new programme, a package of preventive and promotive services should be provided, which would specifically aim for the total development of the child in rural areas and urban slums. This scheme, the Integrated Child Development Scheme, was formally launched in 1975, on October 2nd, Mahatma Gandhi's birthday, in 33 taluks of the country.

4. In the area of Health and Medical Services, several preventive programmes have been in operation through a clinic approach even in the 1960s. Clinic based immunization and family planning services were being provided for promotion of maternal and child health, and family planning since 1962. Gradually, these sporadic activities were organized into the Expanded Programme of Immunization and other Programmes, and implemented all over the country, with the objective that every child and mother in the country should be covered for preventive, promotive and nutritional services.

5. Health For All by the year 2000

With the Declaration of Alma-Ata in 1978, 108 countries of the world including India, undertook to guarantee certain minimum standards of health (which implies certain minimum nutritional standards) to every man, woman and child in their country, by the year 2000. The minimum standard of H F A to be achieved on a global basis was defined in terms of objective indicators as shown in Table-I. The present level for India as a whole and Karnataka in particular are also indicated. Keeping these in view, the present level of health, and interim goals by 1990 to be achieved are also indicated. The achievement of these goals depends greatly upon the success of the health and nutritional programmes.

6. To achieve the HFA goals, a major effort is being made at National and State levels to achieve peak performance of all programmes and at the same time, to critically evaluate the performance and achieve-







ment of the programme objectives, at all levels, so as to identify and implement the required management strategies to ensure achievement of the HFA goals by 2000 if not earlier.

Table - 1  
Present Status of Mother and Child Health and the HFA Goals.

Indicator	Current Level (1989)		Goals			
			India		Karnataka	
	India	Karnataka	1990	HFA2000	1990	2000
Infant Mortality rate (per 1000 live births)	96	75	87	<60	<u>70</u>	<60
Prenatal Mortality	48	37	-	<30	<u>35</u>	<30
1-5 year pre-school child mortality	24	19	20	10	<u>17</u>	10
Maternal Mortality Rate per thousand live births	3-4	3	2-3	Below 1	<u>2-3</u>	<0.5
Pregnant Mothers receiving ante-natal care	40	50	60-75	100	<u>70</u>	100

Source: Government of Karnataka, Technology Mission on Immunization -- Karnataka, 1990

## B. MAJOR HEALTH AND NUTRITION PROGRAMMES

7. Presently, there are six major programmes which are being implemented for health and nutritional status improvement of women and children. Except the ICDS programme, the remaining five programmes are unisectoral, being implemented by a single Department. A notable exception is the ICDS programme which involves a joint effort by two Departments, namely the Department of Women and Children's Welfare and Department of Health and Family Welfare. The programmes and implementing agencies are listed below:







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- (i) Integrated Child Development Scheme : Implemented by the Department of Women and Children's Welfare in Coordination with the Department of Health and Family Welfare
- ii) Special Nutrition Programme (in urban and tribal areas) : Implemented by the staff of Department of Women and Children's Welfare under the direction and administrative control of the Town Municipalities, and Tribal Development Block Administration
- iii) Immunization of children under six years and pregnant mothers : Implemented by the Department of Health and Family Welfare.
- iv) Prophylaxis against Nutritional anemia in Women & Children : -do-
- v) Vitamin A Prophylaxis against nutritional blindness in children : -do-
- vi) Mid-day Meal Programme for school children (6-10 years of age attending class I-V) : Implemented by the Department of Education

#### I. INTEGRATED CHILD DEVELOPMENT SERVICES PROGRAMME

8. Keeping in view the critical need to provide supplementary nutrition to children under six years of age to ensure healthy physical growth and development, and also the need for an integrated package of child health and welfare services through one single agency, the ICDS programme was launched on October 2nd, 1975, in 33 taluks spread all over the country; each taluk was designated as one ICDS Project.

9. The objectives of the ICDS scheme are as follows:

- i) To improve the nutritional and health status of children in the age group 0-6 years;
- ii) To lay the foundations for proper psychological, physical and social development of the child;







- iii) To reduce the incidence of mortality, morbidity, malnutrition, and school dropout;
- iv) To achieve effective coordinated policy and its implementation among the various departments to promote child development;
- v) To enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

10. The ICDS programme is implemented by the Department of Women and Children's Welfare. It aims to provide a package of services to children below six years of age towards achieving the objectives of the programme. The package of services includes supplementary feeding, non-formal pre-school education, immunization, periodical health checkups, referral and medical services, supplementary nutrition to pregnant and lactating mothers, and nutrition and health education to mothers. Since 1976-77, when 333 ICDS projects became operational in the country with Central assistance, by now there are over 2000 ICDS Projects in the country assisted by the Union Government. Under the Scheme, every village (in the ICDS taluk) with a population of about 1000 or more in rural areas and 700 in tribal areas has an Anganwadi centre where supplementary nutrition is provided to approximately 80 children between the age of six months to six years, with priority being given to children belonging to the economically weaker sections (EWS) of the village. Thus, approximately 40% of the expected 170 undersix children (in a village of about 1000 population) are expected to be covered by supplementary nutrition. Apart from the EWS children, children of better-off households who are found to suffer from moderate or severe malnutrition are eligible to be enrolled for the supplementary nutrition. The supplementary food consists of a nutritious mid-day meal, providing about 300 calories and 12-15 gms of good quality protein for children of 1-6 years, at a cost of 50 paise per beneficiary, and for children below one year, food containing 200 calories with 8-10 gms of protein is to be provided. For children with severe malnutrition (Grade III & IV), as well as for pregnant and lactating mothers, double the amount namely, 600 calories, is to be provided.

11. Pre-school education is offered to all children of the village in the age group of 3-6 years, who come to the school. About 40-60 children are expected to enroll for non-formal education at each anganwadi. Also, the anganwadi workers are specifically trained to provide non-formal education to this age group.

12. All children below six years of age in the village are eligible for a three monthly growth monitoring and health checkup, referral services, coverage for immunization, Vitamin A administration, and







anemia prophylaxis through distribution of iron and folic acid tablets. Growth monitoring of the children availing supplementary nutrition at the Anganwadi is to be done every month through weighing of the child and recording in the Road-to Health cards which are provided for the purpose. The children not attending for supplementary nutrition (those who are normally or mildly under nourished and those belonging to the well-to-do families who are not availing supplementary nutrition) are eligible for a three-monthly recording of weight. In addition to the Anganwadi worker's checkup, a three monthly health checkup is expected to be carried out by the visiting Medical Officer, of every child attending the Anganwadi for supplementary nutrition.

13. The Anganwadi worker is expected to function closely with Health Worker (Female) of the related subcentre, to ensure coverage of all children in her village for immunization, Vitamin A administration and nutritional anemia prophylaxis. The Anganwadi workers are honorary functionaries, usually married and settled women belonging to the same village. They are expected to provide their services during the morning hours from 9:00 AM to 1:00 PM at the Anganwadi and regular home visits from 3-5 PM. The Anganwadi Worker (AWW) is trained for three months in nutrition, pre-school education and community development activities at Anganwadi Training Centres. She is assisted by a helper who is also a honorary worker. The helper assists the AWW in the preparation of food, assists in maintaining cleanliness and hygiene of the children, cleaning the Anganwadi, as well as to escort young children to and from their homes. The Anganwadi worker is paid an honorarium of Rs.275/- per month, if she is a matriculate and Rs.225/- per month, if she is a non-matriculate. The helper is paid an honorarium of Rs.110/- per month. The Anganwadi workers function under the leadership and administrative control of the Child Development Project Officer (CDPO) in charge of the Project (taluk). Continuous supervision and guidance to the Anganwadi workers is expected to be provided during the monthly visits to the Anganwadi by the Anganwadi Supervisors who are appointed at the rate of one for every 20 Anganwadis in rural areas; one supervisor for every 17 tribal anganwadis and one supervisor for every 25 urban anganwadis. The supervisors should be females and graduates trained to work in the ICDS programme.

14. The ICDS Projects sanctioned in the Central sector are funded by Central Government for the recurrent administrative and training expenditure, as well as the initial cost of establishing the Child Development Project Offices and purchase of vehicles. The share of the Central Government amounts to 40% of the annual recurring cost and the remaining 60% i.e. supplementary nutrition expenditure, is borne by State Government under the Minimum needs Programme.

15. Apart from the Centrally aided ICDS Projects, each State, keeping in view the urgency of the need in specific areas, implements State Sector Projects in needy areas which could not be accommodated among







the Projects sanctioned under the Central Sector during the year. In the State Projects, provision is made for a maximum of 100 Anganwadis for approximately one lakh population only, irrespective of the actual population of the taluk. In the State Projects, the State Government is totally responsible for all expenditure, the State Government is totally responsible for all expenditure - administrative as well as on supplementary nutrition.

16. The ICDS programme is financially assisted by the international agencies namely UNICEF and CARE. Assistance by UNICEF is in the form of providing vehicles, pre-school teaching kits, weighing scales for weighing children, scales to weigh the food commodities, utensils and the essential drugs kit. UNICEF does not assist in the recurring expenditure of the ICDS projects. Assistance from CARE is in the form of provision of basic food materials namely Corn Soya Blend (CSB) and soya bean oil at the rate of 60 gms of CSB and 8 gms oil per beneficiary. CARE assistance in the ICDS programme has been expanding every year, concomitant with the winding up of CARE aid to the School Mid Day Meal Programme. Certain contiguous districts of the State are earmarked for CARE assistance. As and when the ICDS projects are sanctioned in these districts, CARE provides additional basic food materials for the newly sanctioned projects. In the CARE-assisted districts, the State Government provides 14 paise per beneficiary per day for purchase of condiments, jaggerry and an additional supplement of pulses to improve the taste and protein content of the food. In the districts, not assisted by CARE, the State Government makes provision for 50 paise per child beneficiary per day. In these districts 80 gms of Energy Food on two days/week, and two days each of wheat and rice recipes, are provided.

17. Apart from the above functions, the ICDS organization has become a valuable resource point for information on under six child morbidity and mortality data and under-six nutritional status data. Also, the ICDS infrastructure is gradually being developed to provide vital event statistics of the area.

#### 18. *Impact of the ICDS Programme at a National Level*

Extensive national level evaluation studies carried out by the Central Technical Committee of the Department of Women and Child Department, Ministry of Human Resource Development, Government of India, have shown a favourable impact of the ICDS programme on the overall maternal and child situation. There was significant improvement in ICDS Project areas with regard to general nutritional status, reduction in infant mortality rate and particularly female child mortality, and reduction in mortality due to diarrhoea and tetanus. Immunization coverage of mothers and children in ICDS areas was significantly better. Vitamin-A administration, coverage for prophylaxis against nutritional anemia among children and mothers, coverage for antenatal







care, all showed some improvement in ICDS areas as compared with non-ICDS areas. Low birth weight (prematurity) was reduced significantly in ICDS areas, and on the whole, the ICDS Programme, in the country appears to have improved the child survival in the ICDS areas (3).

## II. IMMUNIZATION PROGRAMME:

### *Evolution of the Immunization Programme*

19. Immunization services for underfive children to prevent the major killer diseases of childhood, namely, Diphtheria, Poliomyelitis, Pertussis, Tetanus and Tuberculosis, have been offered to children in the country since the early sixties through a Clinic approach, at Government dispensaries and hospitals.

20. In 1978, the immunization services being offered in the country were formally organized to be delivered as a package of services, in a systematic manner throughout the country in urban as well as rural areas, under the Expanded Programme of Immunization. The objective of the EPI at the start of the Programme was to immunize every child against the major killer disease namely diphtheria, pertussis, tetanus, poliomyelitis and tuberculosis; and to protect infants from tetanus by immunization of pregnant mothers. In 1985, the measles vaccine was introduced in EPI to additionally protect the child against measles also. Under the EPI, a package of immunization services namely DPT, Oral Polio, Vaccine, and BCG were to be given to all infants as per a prescribed schedule within a certain age. These vaccinations were to be provided through the existing general health services, namely the Primary Health Centres which are responsible to cover a definite population. The District Health Officer was responsible for EPI implementation, along with implementation of all other health and family planning programmes.

21. Under EPI, definite number of targeted children (number of expected births) to be covered were established for each State, and the State in turn distributed the targets to the districts depending upon the number of children expected to be born in the district. Similarly, immunization for pregnant mothers with tetanus toxoid (initially fixed at three doses and subsequently modified to two doses) to prevent neonatal tetanus was also a part of the Expanded Programme of Immunization. The targetted number of mothers to be given tetanus toxoid was also based on the number of births expected to take place in the districts. The State Directorates as well as the Government of India monitored the performance of the immunization programme through the figures of achievement furnished by the Districts.







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22. By the early eighties, the coverage (achievement of targets) of immunization remained far behind expectation, and it became clear that significant proportion of infants were not being protected by vaccination, particularly in rural areas. Many logistic problems, particularly relating to cold chain maintenance from production of vaccine to delivery to the child, and problems of timely coverage of infants due to lack of staff/ infrastructure supplies, were serious constraints. On the other hand, immunization technology had immense potential to prevent child deaths, promote child survival and indirectly influence family planning practices, a potential which simply could not be ignored. The National Goal of Health For All by 2000 implies universal immunization of children and mothers in the country. Therefore, with a view to make a concerted national effort to bring all infants and pregnant mothers in the country under immunization, irrespective of the specific problems of any area, backward, remote, rural or tribal, the Universal Immunization Programme was devised in 1985-86.

#### *Universal Immunization Programme (UIP)*

23. The objectives of the UIP are as follows:

##### A. General Objectives

- To reduce Infant and Child Mortality due to Six Vaccine Preventable Diseases
- To Reduce Morbidity and Disabilities produced by these diseases in the surviving children

##### B. Specific Objectives

- a. To Immunize 100% of pregnant women by 1990 and thereafter every year (About 13 lakh pregnant women every year in Karnataka State);
- b. To achieve full immunization coverage of 100% infants, with 3 doses of DPT, 3 doses of Oral Polio, one dose of BCG and one dose of Measles before they complete one year of age (about 12 lakh infants in Karnataka every year);
- c. To reduce the incidence of paralytic poliomyelitis to less than 1 per lakh population from existing 3 per lakh population and to eradicate poliomyelitis by 2000 AD
- d. To reduce Neonatal Tetanus incidence to less than one per thousand and births from existing three per thousand births.







4. Under the UIP, which is partly funded by UNICEF, all logistic problems are to be taken care of by the UIP organization headed by the District Immunization Officer. Thus, UIP is charged with the responsibility of providing effective cold chain equipments right up to the periphery, ensuring transportation to reach out to the remotest areas, ensure timely supply of vaccine, and management inputs to ensure mobilization of every available local resources -- human and material, for timely coverage of all eligible children and mothers. Under the Universal Immunization Programme, an intensive drive during the three months of the year - the winter season is envisaged. All PHC staff are intensively engaged in providing immunization, door to door during this period. (This period has been found to be most appropriate keeping in view the climatic conditions and lax period as far as FP programme is concerned, when the PHC staff can be mobilized to concentrate on the UIP).

25. The District Immunization Officer is also responsible to help the Primary Health Centre Medical Officers to draw up detailed plans in covering their respective populations, ensuring maintenance of all cold chain equipment in working order, and arranging for systematic monitoring to ensure high potency of vaccine at the peripheral most point until immunization is actually delivered.

26. The Universal immunization Programme is being implemented in a phased manner with a few Districts in each State being taken up, year after year. The philosophy of the UIP is that no child under one year of age in the UIP covered district should be left uncovered by vaccination and also that all pregnant mothers should be covered for tetanus toxoid.

27. *Technology Mission on Immunization:* Following the introduction of UIP, reviews of the immunization programme in the country showed that while coverage was satisfactory in most districts, in certain others, in spite of implementing the UIP, shortfalls of achievement were taking place. This feature was highlighted by UIP Vaccination Coverage Surveys. A deeper analysis of the problem showed that timely arrival of the vaccine supplies to the different levels was not taking place and this prevented timely immunization of the infant. To overcome this handicap and to ensure speedy resolution of these logistic problems, the Universal Immunization Programme was brought under the purview of the Technology Mission in 1989. As a result, for the first time a high level officer of the Central Government of the rank of Joint Secretary was designated to UIP with full financial powers to take all expedient steps considered necessary for speedy resolution of logistic and supplies problems.

With this step, the Immunization programme has received a further boost and it is expected that by 1990, 100% of the eligibles - infants and pregnant mothers will be fully immunized.







### III. VITAMIN A PROPHYLAXIS AGAINST NUTRITIONAL BLINDNESS IN CHILDREN

28. Nutritional surveys during the sixties conducted on a country-wide basis showed that children, particularly in the age group one to five years, were susceptible to Vitamin A deficiency. Five to ten percent of these children show signs of Vitamin A deficiency which leads to blindness in many cases. It is estimated that in India alone seven million children suffer from Vitamin A Deficiency of whom 42000 become totally blind and 78000 suffer from poor vision (6). Clinically, Vitamin A deficiency is manifested in the eyes, in the form of conjunctival xerosis, Bitot's spots and Keratomalacia, which is followed by ulceration of the cornea and blindness.

29. Vitamin A deficiency is caused by inadequate dietary intake of greenleafy vegetables and milk. It was found that administration of two lakh units of Vitamin A to children age one to five years, every six months, substantially reduces the risk of nutritional blindness. Following this finding, the National Programme of Vitamin A administration against nutritional blindness was initiated to prevent nutritional blindness in children. Under this programme, a massive dose of two lakh units of Vitamin A is administered twice a year to children between the ages of one to five years. Under this programme, Karnataka State has a target of 30 lakh children of the age group one to five years (which includes all children of this age group in the State). Vitamin A is expected to be given by the Health Workers (Female) during the months of July and December, during her routine home visits in the villages under her care.

### IV. PROPHYLAXIS AGAINST NUTRITIONAL ANEMIA FOR MOTHERS AND CHILDREN

30. Pregnant women are particularly prone to develop nutritional anemia which increases the risk of infant death as well as maternal death. Children of the age one year and above are also prone to develop nutritional anemia due to inadequate dietary intake. In order to prevent nutritional anemia, pregnant mothers are expected to be provided iron and folic acid tablets during pregnancy by the Health Workers (Female), Lady Health Visitor or Medical Officer as part of antenatal care. 100 tablets are to be given in two installments to the mothers to be consumed at the rate of one tablet daily, during the second or third trimester of pregnancy. In case of children below six years of age, one hundred tablets of iron and folic acid are to be provided for every child in two installments.

31. The Anganwadi workers in the ICDS taluks are expected to work closely with the Health Worker (female) to reach out to these two population groups who are already under the ICDS coverage to ensure cent percent coverage of the targeted population, with iron and folic acid supplementation.







## V. SPECIAL NUTRITION PROGRAMME

32. The Special Nutrition Programme was one of the earliest nutrition supplementation programmes introduced by the Government of India. It was initiated in 1970-71, for under-five children and pregnant and lactating mothers in the slums of cities and small towns, as well as in tribal areas.

33. The objective of the Special Nutrition Programme is to improve the nutritional status of children under the age of five specifically in the urban slums and tribal areas.

34. The supplementary food provided costs the Government approximately 50 paise per beneficiary, and it consists of milk and bread slices, or about 80 gms of Energy Food which is a blend of roasted wheat, bengal gram, groundnuts and jaggery. In some SNP Centres, beneficiaries are provided with a 15 days supply of soya fortified bulgar wheat which is to be cooked and consumed at home. Beneficiaries eligible for the supplement are those whose family income is Rs.200/- or less per month.

35. This programme is essentially a food distribution programme; food is distributed through honorary local persons of slum areas who are paid an honorarium of Rs.30/- per month. These supervisors are assisted by Helpers who are paid Rs.15/- per month. The supervisors are in charge of food distribution at the slum level which is to be done at a specified time every day; they work under the supervision of the Special Nutrition Programme Food Inspectors who function under the Municipal bodies or Tribal development Block Officers. The administration of SNP programme related to supplies and funds for honoraria is the responsibility of the Department of Women and Children's Welfare. Unlike the ICDS Programme, under SNP, there is no system of enumerating beneficiaries, monitoring utilization of the services, or health services to the beneficiaries.

36. Evaluation of the urban component of Special Nutrition Programme has shown that the Programme had a favourable impact on body weight of the target groups (5) which shows that SNP has begun making some impact on the nutritional status of women and children. This programme is being gradually wound up with the introduction of ICDS in urban areas and the SNP centres are being converted into ICDS Centres with provision of Integrated Child Development Services which has supplementary nutrition as one of the components.







## VI. SCHOOL MID-DAY MEAL PROGRAMME

37. The School Mid-day Meal Programme was the earliest nutrition supplementation programmes introduced in the country. It was started in 1963 with the assistance of the American Food Aid Agency, CARE. The objectives of the Programme are:

- i. To effectively implement Compulsory primary school education;
- ii. To improve Primary school enrollment of children in the age group 5-10 years and thus promote literacy;
- iii. To improve attendance of children at Primary Schools
- iv. To improve the nutritional status of children in this age group; and,
- v. Through improvement of nutritional status, to improve the scholastic achievement of the children.

38. Under the Programme, food materials namely, corn, soya meal, bulgar wheat, and soya bean oil was being provided by CARE to be cooked into a nutritious supplement for primary school children of class I - IV. The programme is administered by the Department of Education with the Joint Director (Mid-day Meals) being overall incharge of the implementation. The cost of transportation of the materials from the United States as well as transportation within the country, the CARE administration costs of its offices in India as well as its supervision costs within each State are borne by the Government of India and the State Governments. In addition to CARE administration costs and costs of transportation to the taluks, an amount of five ps per child beneficiary is allocated by the State Government to cover the costs of transport of food material from taluk headquarter to the school, costs of fuel and condiments such as onions, chillies, etc., to prepare the food. Each child is provided with food cooked from 80 gms of (dry weight) bulgar wheat and five gms of oil with the additional condiments. This is expected to provide about 10 grams of protein along with vitamins and fats.

39. Beginning with a coverage of 4.67 lakh school and preschool beneficiaries in Karnataka State in 1963-64 fully supported by CARE, the Programme was gradually expanded till 1972-73, when a total of 17.60 lakh beneficiaries (including 11.74 lakh school children) were being covered. Subsequently CARE involvement has been gradually withdrawn. Until 1980-81, 10.5 lakh school children were covered (approximately 32.5% of schools) and by 1988-89 seven lakh school children were covered with CARE food assistance. In 1980-81, the State Government of Karnataka stepped in to provide a substitute supplementary







food, namely Energy Food, to 1.8 lakh beneficiaries, in order to augment the CARE Mid-day Meal Programme which was gradually reducing coverage from year to year. With the gradual withdrawal of CARE, the State Government has been bringing more beneficiaries under the Energy Food Programme, so as to atleast maintain the number of Mid-day Meal beneficiaries at approximately 12 lakhs in the State.

40. During 1986-87, an Evaluation of the Mid-day Meal Programme by the Department of Education of the Government of Karnataka based on Departmental statistics and opinion survey of the school children and teachers came to the following conclusions: The School Mid-day Meal programme did not produce significant changes of reported school enrollment, attendance or scholastic achievement ( in terms of reported passing from year to year) as shown by the similar performance of schools with or without the programme. However, the opinion survey showed that both students and teachers were in favour of continuation of the Programme with some suggested modifications.

41. Keeping in view the present tight resource situation and yet the critical need to develop the quality of our national human resources through promotion of literacy and good nutritional status, the Mid-day Meal Programme needs to be critically reviewed with regard to its implementation and achievement of the Programme objectives, so as to enable suitable management actions for best utilization of resources.

## VII. SCHEMES FOR SOCIOECONOMIC DEVELOPMENT OF WOMEN

42. Apart from the Statewide Programmes for health and nutritional development of women and children, many innovative schemes have been initiated by the Department of Women and Children's Welfare at National as well as State levels, to mobilize women in the developmental process, to indirectly promote women's health, to promote women's active participation in the health and nutrition programmes, to improve economic status of women, and to improve the status of women in the society and family. Such activities by women are known to affect the women's biological role as mothers. The major schemes are reviewed here.

### A. *Maternity Allowance to Agricultural Landless Women Labourers in Karnataka*

43. This scheme was launched in 1984-85 by the Government of Karnataka with a view to provide financial support to agricultural landless women labourers during advanced pregnancy, limited to their first two pregnancies only. The objective of the financial assistance is that the lady can have rest and good nutrition during late pregnancy and the postnatal period. A sum of Rs.300/- is to be provided to the woman through the Primary Health Care covering the area, in the last







trimester of pregnancy, after being certified to belong to the eligible income category by the village accountant. The Department of Women and Children's is responsible for sanction of funds, which are transferred to the District Health Officer for disbursement by the Health Department. However, the Department of Women and Children's Welfare is accountable for proper utilization, without the authority to ensure implementation as per norms.

**B. Subsidy Scheme for Income Generation Activities by Women  
Grihakalyana Scheme**

44. This scheme was started by the Government of Karnataka in 1982-83. The objective of the scheme is to promote income generating activities by women so as to help improve family income, and also to improve women's status in the family. It is extended by the Department of Women and Children's Welfare to women in urban and semiurban areas (taluk headquarter town and any other town) in the ICDS project areas only.

45. The Child Development Project Officer along with Anganwadi supervisors are responsible to identify and motivate women with a family income less than Rs.3000, to start a small business or trade on their own. The income is certified by the Tahsildar. The CDPO works with the Banks to mobilize a loan for the identified women to the tune of 75% of the required amount at 4% interest. 25% is given as subsidy by the Department (to a maximum of Rs.1250/-). Thus the ceiling for the loan is Rs.5000/-. The role of the CDPO and his team has been in:

- i) Identifying the beneficiary
- ii) Working with tahsildar to get income certificates for the applicants
- iii) Negotiating with Banks to provide the Loan component
- iv) Follow-up with the beneficiary to ensure loan repayment.

**C. Creches for Children of Working Women**

46. The Department of Women and Children's Welfare assists voluntary organizations to start creches for children of working women in rural areas who are agricultural or casual labourers. Under this scheme the Government provides Rs.505/- per month to voluntary organizations in the rural areas for running creches to look after a minimum 25 children daily for 25 days of the month. The grant is expected to provide 90% of the cost of operation of the creche; grants made under this scheme are fully reimbursed by Government of India.







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D. *Assistance to Voluntary Organizations to Run Women's Training Centres for Women in Districts*

47. Voluntary organizations which train atleast forty women at a time in skills of the livelihood trade are given financial assistance to run the training programme.

E. *Mahila Mandals and Taluk Level Federation of Mahila Mandals*

48. Under this scheme, the Government makes provision for assisting a Mahila Mandal Federation in every ICDS taluk, to promote development of women's organizations i.e. Mahila Mandals in the villages. The Mahila Mandal is expected to become the hub of community participation in child health programme. Once established, grants are given to Taluka Mahila Federations to promote women's development activities in the villages such as purchase of sewing machines for tailoring classes, etc. In case of the Central Sector ICDS projects, the expenditure on Mahila Mandals is fully reimbursable by the Government of India.

F. *Other Schemes*

49. Several other schemes have been started for welfare of women and children. These are mostly limited to very specific target groups and limited in scope as far as the overall women's health and development in Karnataka is concerned. These programmes are listed below:

a) Financial Assistance to needy women to undergo short term job training in skills of livelihood (Rs.500/-) per candidate per annum. Mostly the assistance has been given for learning typing skills.

b. Working women's Hostels: Construction grants are provided to registered voluntary organizations by the Government of India to the extent of 75% of the estimated cost, 12.5% to be borne by the State Government, and 12.5% to be borne by the voluntary organizations.

c. Financial assistance to destitute widows for remarriage and devadasi marriage

d. Scheme of pension to destitute widows in Karnataka

e. Special cell for eradication of social evils

50. To summarize, the major National programmes being implemented by the Government of Karnataka towards health and nutritional development of women and children in Karnataka are as follows:

a. *The Integrated Child Development Scheme*

b. *Special Nutrition Programme*







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- c. Immunization Programme
- d. Prophylaxis against Nutritional Anemia in women and Children
- e. Prophylaxis against Nutritional Blindness among 1-5 year old children
- f. School Mid-day Meal Programme
- g. Mahila Mandal Scheme, and
- h. Creches for Children of Working Mothers in rural areas

The major programmes initiated by the State Government are as follows:

- a. Maternity Allowance Scheme for Landless Agricultural Labourers and (b) Grihakalyana Scheme.







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#### REFERENCES

1. Government of Karnataka: Manual of Schemes Under Plan: Department of Women and Children's Welfare, Directorate of Women and Children's Welfare - Bangalore 1983-84
2. Indian Council of Medical Research : Studies on Pre-school Children ICMR Technical Report Series No.26, New Delhi.
3. Government of India: ICDS - Evaluation and Research 1975-1988 Central Technical Committee, Department of Women and Child Department, Government of India, New Delhi, 1990
4. Nagaraja, Bhargavi: Sub-six Children in ICDS Focus. Deccan Herald, October 20, 1990, Bangalore
5. Institute for Social and Economic Change: Child in Karnataka - A Situational Analysis: Population Research Centre, Bangalore, p.37, pp 56-59
6. Gupta V P: The Scourge of Malnutrition: Indian Express, February 28, 1990, Bangalore
7. National Institute of Public Cooperation and Child Development, Manual on Integrated Child Development Series: New Delhi, 1984







## Chapter - II

## HEALTH AND NUTRITIONAL STATUS OF WOMEN AND CHILDREN IN KARNATAKA AND THE STUDY DISTRICTS

*In the light of National and State level programmes reviewed in Chapter I, this Chapter presents a situational analysis of health and nutritional status of women and children in Karnataka and the two study districts, in terms of the following indicators, namely, Socio-economic status of women - literacy, women agricultural labourers and general level of poverty; child health indicators - infant mortality rate, preschool child mortality rate, caloric intake, preschool child malnutrition rates, incidence of vaccine preventable diseases; maternal health indicators - maternal mortality, age at marriage, fertility and parity, fertility below the age of 19 and, couple protection with family planning.*

## I. HEALTH OF WOMEN AND CHILDREN

1. The most vulnerable groups constituting a major section of the population (nearly 62% in Karnataka) are the children, particularly under six years of age, and women in the reproductive age group (15-49 years). In developing countries, both these groups are characterized by higher risk of ill-health, poor nutritional status, and mortality, compared with the adult males or the general population. The higher vulnerability of children, particularly of under six children, arises from four major risk factors - low birth weight due to poor maternal nutrition during pregnancy; inadequate food intake, particularly of calories protein and vitamin A with serious health consequences; susceptibility to the five major killer/crippling diseases of childhood all of which are vaccine preventable (diphtheria, tetanus, poliomyelitis, whooping cough, tuberculosis and measles); and risk of death due to diarrhoea - a major killer in infancy. These risk factors lead to poor health and nutritional status which increase the susceptibility of the child further. The overall situation of the child can thus be understood in terms of several indicators namely; infant mortality rate (IMR) low birth weight, under-five mortality rate; prevalence of under-five malnutrition; incidence rates of neonatal tetanus, and other vaccine preventable diseases.

2. Maternal health, nutritional status and health practices closely influence the course of the child health and child survival. The higher vulnerability of mother's health arises chiefly from the reproductive role. The status of maternal health, nutrition and health practices, besides being reflected in the child health indicators as







listed above, is also reflected directly or indirectly through the following indicators, namely maternal mortality rate; maternal risk factors such as, parity of mothers; age at marriage; fertility during adolescence; dietary intake during pregnancy and lactation; proportion of fourth and higher order births (a high risk factor for infant and child mortality); proportion of women with low body weight; and practice of birth spacing and family planning.

3. Apart from these direct maternal and child factors and indicators, the socioeconomic factors which influence maternal health indirectly are : overall poverty levels (percentage of people below the poverty line), proportion of women working as agricultural labourers, and female literacy. Special strategies and programmes aiming at specific target groups would be needed to tackle weaknesses in these areas.

4. Thus, the interventions required to impact the mother and child situation will need to have a multisectoral approach, requiring organised effort by professionals and administrators of many disciplines. Also programmes initiated by each Department Medical, Women and Child Welfare, Agriculture, Forestry or any other, will be required to have a multipronged approach along with close coordination between Departments to ensure efficient achievement of the overall objective, namely, the improvement of maternal and child health and nutritional status. The following paragraphs summarize the status of the mother and child in the state as in the backward districts.

## II. SOCIOECONOMIC INDICATORS

### a. Poverty:

5. Poverty influences the purchasing power to procure and consume food, in terms of quantity and quality. The poverty situation in Karnataka as compared with the neighbouring States and India as a whole is presented in table 2:

Table - 2,  
Percentage of population below poverty line - 1983-84 (Provisional)

	Rural	Urban	Combined
Karnataka	37.5	29.2	35.0
All India	40.4	28.1	37.4
Andhra Pradesh	38.8	29.5	36.4
Kerala	26.1	30.1	26.8
Tamil Nadu	44.1	30.9	39.6





6. On the whole, the situation in Karnataka was similar or slightly better than the rest of the country. Karnataka was better placed than Tamil Nadu but not as well placed as Kerala. Data on poverty levels for Gulbarga and Raichur districts separately were not available. Indirect comparisons of family income as reported by the National Sample Survey (2) and the Baseline survey on Health and Family Welfare Status of the Population in IPP districts (3) showed that, while in Karnataka as whole, about 50% of households were living at subsistence level or below (i.e. Rs.3/- per capita per day in rural areas and Rs. 4.50 in urban); in Gulbarga and Raichur districts, this proportion was approximately 53.6 and 61.3% respectively (3). Thus the situation in Gulbarga was slightly poorer in terms of poverty, and Raichur was far worse than Karnataka as a whole in terms of proportion of people living below subsistence level. In fact, Raichur showed 24.6% of households with less than Rs.2000/- annual income which comes to less than Rs.1/- per capita per day in these households in 1984.

b. Literacy:

7. The overall literacy situation is summarized in Table-3 (6,12)

Table-3

Literacy Rate among General Population and Females(1981 Census)

	Literacy Rate	
	General	Female
India	36.2	24.8
Karnataka -		
General	38.5	27.0
Rural	31.0	19.8
Gulbarga District	24.9	13.3
		(7% rural)
Raichur District	24.7	13.6
		(7% rural)

Thus, Karnataka was again average, with regard to general and female literacy. In Gulbarga and Raichur districts, the situation was poorest in the State with 7% rural female literacy. The literacy rate closely influences maternal antenatal practices, immunization, child care and feeding practices as well as fertility behaviour and contraception, which have a direct bearing on maternal and child health.







c Female Marginal Workers/Agricultural Labourers

8. One in every six women in Karnataka was working as against one in every seven in India; totally 4.6 million females in Karnataka State were in rural areas and almost all of them were agricultural labourers (4). This situation greatly influences maternal nutrition and health as well as birth weight and child survival. Special Programmes and strategies are needed to tackle the complex interplay of women's income, maternal nutrition and need for rest during pregnancy and early lactation.

III. CHILD HEALTH INDICATORS

a. Infant Mortality Rate:

9. Infant mortality rate is the single most sensitive indicator which sums up all the factors and reflects the child situation. The IMR in the country as a whole, Karnataka, and the study Districts are presented in the following table.

Table -4  
Current level of Infant Mortality Rate in India, Karnataka and the Study Districts

IMR (Rate/1000 live	
India*	96
Karnataka*	75
Gulbarga District**	118.9
Raichur District**	57.7

Source \* Government of Karnataka: Technology Mission on Immunization, Karnataka 1990

\*\* Government of Karnataka, Health and Family Welfare States of the Population -Final Report on Baseline Survey IPP-III Karnataka Population Centre, Bangalore 1988.

Thus, while Karnataka as a whole, is better off compared to India as a whole, the IMR in Gulbarga district is definitely unfavourable at 118.9/1000. However Raichur district is better placed than Karnataka as whole.







b. Pre-school Child Mortality Rate:

10. The pre-school child mortality rate per thousand for India was 24 per thousand in 1-5 age group of children; in Karnataka it was 19/1000; in the two district of Gulbarga it was 18.1 in the 1-4 age group, and in Raichur it was 7 per thousand(5). Thus, between Gulbarga and Raichur, Raichur had a far better child situation as compared with Gulbarga.

c. Nutritional Status of Pre School Children

11. The present level of nutritional status of 0-6 years children for India as a whole(7) and the two study districts (8) are presented in the following table :

Table -5  
Nutritional Status of Children

	Nutritional Status by Weight(%)					
	Normal	Grade-I (Mild mal.Nut.)	(II Mode- rate mal- nut.)	III&IV (Severe mal.Nut.)	Vit.A Defi- ciency	B-Com plex defici- ency
India(7) (Non ICDS areas) (0-6 years)	35.4	28.9	24.7	11.0	17.3	14.1%*
Karnataka(8) (1 -5 years)	11.0	44.0	38.0	7.0	-	-
Gulbarga(8) (1-5 years)	NA	NA	NA	12.7	5*	7.6%*
Raichur(8) (1-5 years)	NA	NA	NA	6.8	5*	7.6%*

\* ICMR findings in Studies on Pre-school Children carried out in 1965 in Hyderabad area (urban and rural) reported in ICMR Technical Report Series No.26, New Delhi, 1986.

Overall the nutritional status of 1-5 year old children in Karnataka was better than for India as a whole. Within Karnataka, the prevalence of severe malnutrition was highest in Gulbarga than in any other district with 12.7% of children being severely malnourished.







d. Incidence of vaccine preventable childhood diseases

12. The incidence of vaccine preventable disease, prominently known, neonatal tetanus and paralytic polio is another important indicator of child health. It particularly reflects the coverage of preventive immunization to mothers and children. The following tables show the comparative situation in India, Karnataka and the Study districts (or comparable Districts ) (10).

Table - 6  
Incidence of Neonatal Tetanus

	Year of survey	Neonatal Tet.Rate/ 1000 live births
Bidar (Gulbarga Division)	Nov.88	6.9
Hassan (Progressive District of Karnataka)	Nov.88	1.6
India 1981 (SRS)	Rural 13.3	Urban 1.6
Karnataka 1981 (SRS)	Rural 5.1	Urban 3.2

\* Source: Government of Karnataka, Universal Immunization Programme in Karnataka, 1990

Table - 7

Results of Paralytic Polio Surveys of Under-fives Prevalence Rates

District & Year of Survey	Paralytic Polio Prevalence/1000 Children
Bidar (85,87,88)	2.1, 2.2, 2.4
Bellary (88)	5.0
Raichur	8.0
Chitradurga	3.6
Hassan	0.6
Shimoga	2.2
Karnataka (1981 Sample Survey)	1.2
India (1981)	1.7

\* Source: Government of Karnataka, Universal Immunization Programme 1990







13. Thus, both in terms of neonatal tetanus and paralytic polio, Karnataka as a whole had a favourable situation compared with the rest of the country. The Districts in Gulbarga division, (comparable districts are Bidar, Bellary and Raichur) showed comparatively higher rates of neonatal tetanus and paralytic polio. There is a great difference between these districts and the progressive districts of Hassan and Shimoga which have traditionally been faring well in respect of achievement of the health and family welfare programmes, suggesting the magnitude of change that can be achieved with excellent or optimum implementation of the maternal and child health programmes.

#### IV. INDICATORS OF MATERNAL HEALTH

14. The picture presented in Table 8 of maternal health and reproductive health indicators also represents and explains some of the above findings of child health.

Table - 8  
Maternal Health and Reproductive Health Indicators

	India	Karnataka	Gulbarga & Raichur (Gulb.Dvn.)
1. Maternal Mortality Rate (10)	3-4/1000	2.3	NA
2. Mean Age at marriage of females(11,12)	18.33	19.2	15.2
3. Average No. of children born per woman below 19 years(11,12)	0.17	0.2	0.7
4. Proportion of 4th and higher order births(8,11) (approx.)	40%	40%	38%
5. Couple protecting rate with FP methods (13,15)	40%	43.6%	35%

The maternal mortality rate is an overall index of reproductive health of mothers and their utilization of health services. Maternal mortality is influenced greatly by age at marriage - young mothers below 19 years of age have twice the risk of dying of maternal causes as also their infants (4). The mean age at marriage in Gulbarga division at 15.2 was much lower than for Karnataka as a whole. In fact it was found in the 1981 census, that 64% of all married girls in Karnataka in the age group of 10-14 years (who were altogether 82,000 in number), were in four districts - Bijapur, Belgaum, Gulbarga and







Raichur (4). Reflecting this situation, the average woman/girl below 19 years in Gulbarga Division had 0.7 full term birth which was very high (11). This means that 7 out of every 10 females below 19 years already had a child. This is in marked contrast to, one in every six women below 19 in India as a whole having a child, and one in every five in Karnataka State.

15. Fourth and higher order births drastically increase the risk of maternal mortality. The proportion of fourth and higher order births among total births was more or less similar in Gulbarga Division as compared with Karnataka (11), probably reflecting a demographic scenario in which larger proportion of young mothers were giving birth to their first, second or third child in the total reproductively active population. The couple protection rate with family planning was also very low in Gulbarga Division.

16. In addition, socio-cultural factors result in high prevalence of protein caloric inadequacy among lactating mothers - 13.4% of lactating mothers in Karnataka had inadequate caloric intake, as compared with an adequate caloric intake by the general population as observed during the period 1975-80. This high proportion with caloric inadequacy was only matched by the age group of children 1-4 years among whom, protein caloric inadequacy was found in 12.3% of children.

17. To Summarize, the average mother and child in Karnataka is better placed than in the country as a whole. However, within Karnataka, the maternal and child situation in Gulbarga division and particularly in Gulbarga district is extremely poor, and possibly the District may rank with the most backward Districts of the country. Between Gulbarga and Raichur, the mother and child situation appears to be far better in Raichur in spite of similarity in certain general indicators such as poverty and literacy levels.





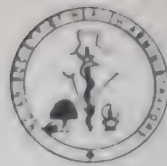


## REFERENCES

1. Institute of Social and Economic Change, Child in Karnataka - A Situational Analysis, Bangalore, 1989 p 17-18.
2. Institute of Social and Economic Change, Child in Karnataka - A Situational Analysis, Bangalore, quoting NSS 1983 DATA PP 15.
3. Government of Karnataka - Health and Family Welfare Status of the Population - Final Report of Baseline Survey IPP-III Districts, Population Centre, Bangalore, 1988 p 125.
4. Institute of Social and Economic Change, Child in Karnataka - A Situational Analysis, Bangalore, 1989 pp 20-23.
5. Government of Karnataka - Health and Family Welfare Status of the Population - Final Report of Baseline Survey IPP-III Districts, Population Centre, Bangalore, 1988 p.126.
6. Government of Karnataka, Department of Health and Family Welfare Status Report 1988-89, Bangalore, 1989.
7. Government of India, Central Technical Committee, Department of Women and Child Development, Ministry of Human Resources Development, ICDS - Evaluation and Research, 1975-78, pp 30-32.
8. Institute of Social and Economic Change, Child in Karnataka - A Situational Analysis, Bangalore, 1989, pp 46-48.
9. Indian Council of Medical Research, Studies on Pre-school Children, ICMR Technical Report Series No.26, New Delhi, 1988.
10. Government of Karnataka - Universal Immunization Programme in Karnataka, 1990.
11. Government of Karnataka, Health and Family Welfare Status of the Population - Final Report of Baseline Survey IPP-III Districts, Population Centre, Bangalore, 1988 pp 32-94.
12. Government of India - Ministry of Health and Family Welfare, Family Welfare Year Book (1986-87) of India, New Delhi, 1988.
13. Indian Society of Health Administrators 'Mid Term Evaluation of India Population Project III - Karnataka State', Bangalore. 1989.







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14. Ghosh, Shanti: in "Health of the High Risk Groups - Mothers, Children and the Elderly", Indian Society of Health Administrators, Bangalore 1988, pp 71-86.
15. Planning Commission, Government of India, India's Population - Policies and Perspectives, New Delhi, May 1989.







## STUDY OBJECTIVES AND METHODOLOGY

*This Study was conducted to assess the impact of various National level and State level programmes on the nutritional status and health of women and children in two districts (drought prone, high poverty and low literacy) of Karnataka State. This chapter outlines the specific objectives and methodology.*

## I. NEED FOR THE STUDY

1. The Indian Society of Health Administrators has been concerned with health of the high risk groups, particularly of women and children. Two of the ISHA annual Conferences were organized on this theme, namely, the 1987 Conference on "Health of the High Risk Groups - Mothers, Children and Elderly" and the 1988 Conference on "Health of Women and Children for Development". At both Conferences, as well as at most other forums, the critical need for a concerted thrust to the concerned National Programmes as well as for a coordinated multisectoral effort, has been highlighted for nutritional and health improvement of children and women so as to reduce infant mortality and maternal mortality.
2. Many programmes have been initiated by different Departments of the Governments of India and Karnataka towards health and nutritional development of women and children in the State (as described in the previous chapters). Towards understanding the magnitude of the total effort for health of women and children cutting across departmental lines, as well as to understand the management issues and impact of these programmes, this Study was initiated. The Study aimed to carry out a comprehensive review of the present performance of these programmes, progress achieved with regard to the original objectives of the Programmes, and the issues involved. Based on these, the study aimed to make recommendations towards effective implementation in the State.
3. Originally the study was designed to cover all districts. Subsequently it was decided to take up, on a pilot basis, two districts only, which was to be followed by a comprehensive study in all districts. Keeping in view the traditional backwardness and consistently poor performance of most Programmes in the Hyderabad-Karnataka area, it was decided to take up the pilot study in the two backward districts of Gulbarga and Raichur.







## II. STUDY OBJECTIVES

4. Towards the above broad objectives of the Study, the following working objectives were established:

- i) To review the Programmes initiated or being carried out by the different Government Departments since 1980, towards health and development of women and children.
- ii) To understand the present status of implementation and achievement of objectives of the Programmes at State level and in the two Study Districts.
- iii) To study in depth, the present status of implementation of the following six programmes directed towards improvement of health of women and children at State level and in the two Study Districts.
  - a. Integrated Child Development Scheme
  - b. Prophylaxis against Blindness due to vitamin A deficiency
  - c. Prophylaxis against Nutritional Anemia among Mothers and Children
  - d. Special Nutrition Programme
  - e. Mid-day Meal Programme
  - f. Expanded Programme of Immunization
  - g. Programmes for Socioeconomic Development of Women
- iv) To study the programmes (a) to (g) at State level and the two Study Districts with regard to the following:
  - a. Eligible population effectively being covered by the Programme
  - b. Management factors influencing the success of implementation - positive factors and constraints
  - c. Involvement of the voluntary agencies
  - d. Results
- v) Based on the above, to make suggestions and recommendations towards more effective implementation of the programmes

## III. STUDY METHODOLOGY

### A. *Nature of Information to be collected*

5. The Study Methodology included collection of information as follows:







- i) Current Literature Review for information on the implementation and impact of the programmes
- ii) Information at State and District Level: Through Interviews and review of records and reports available with programme officers of Departments of Women and Child Welfare, Health and Family Welfare and Education, to collect information on quantitative and qualitative aspects of the following:
  - a. Present status of implementation
  - b. Resource analysis, finances available, and infrastructure
  - c. Organizational structure for implementation
  - d. Coordination, supervision, monitoring and control
  - e. Involvement of voluntary agencies
- iii) Information at Project/Unit/Primary School level: Similar information as indicated above was collected at the level of selected Project/Units.
- iv) Information from Voluntary Agencies: A few voluntary agencies being assisted by the Government in the district were visited to assess their contribution to the programme, and achievement vis-a-vis expectations by the Government agency enlisting participation.
- v) Interview of selected beneficiary families: Beneficiary families listed under ICDS were selected from each village for information on their utilization, and benefits gained from all the various programmes launched by the Departments of Women and Child Welfare, Health, and Education. A sample of children attending the anganwadis were clinically assessed for general health and signs and symptoms of malnutrition.
- vi) Interviews of selected students of primary schools: Primary school children of selected schools with and without midday meal were interviewed and clinically examined to assess the implementation, utilization and results of the school mid-day meal programme.
- vii) Family Planning Association Units at Gulbarga and Raichur Units were visited to study their programmes in the two districts.

## B. Sampling Population

6. In each of the two Study Districts, a sample of taluks were selected for detailed study. In Gulbarga District, three taluks were selected at random from the eight (functioning) ICDS taluks. In Raichur, two taluks were selected out of four ICDS taluks.







7. In each of the taluks selected, two Anganwadis were selected. For selection, the anganwadis were classified keeping in view two major variables which were reported to critically influence the functioning of an anganwadi. These factors were, distance from the taluk headquarters, and frequency of supervision by the supervisor. Anganwadi selection was made after drawing up a list of anganwadis situated 10 kms or more from the taluk headquarter. These were classified into (a) anganwadis with average frequency of supervision (b) anganwadis which were infrequently or never supervised for whatever reason. One anganwadi from each group was selected in each taluk giving a total of ten anganwadis. (It was reported by all Projects that each of these two groups tend to account for about 30-40% of anganwadi villages in the Projects; therefore it was surmised that the group of selected anganwadis would give a fair picture of the grass-root level implementation and impact of the ICDS Programme, in the Projects).

8. In every anganwadi village, in addition to assessment of anganwadis functioning, a household survey of about 20-25 families (in which children were availing supplementary nutrition) were interviewed to assess the following:

- a) Outreach and utilization of the health and nutritional programmes
- b. Child care, nutrition, sanitation and personal hygiene practices (which indirectly influence child health).
- c. Influence of the anganwadi services and health services being felt and practiced by the people.
- d. Outreach and impact of the socioeconomic development programmes for women.

9. A total of 175 ICDS beneficiary families were interviewed in the two districts. In addition, 41 non-beneficiary families (families not availing ICDS supplementary nutrition) were also interviewed to assess the differences in practices and outreach of health programmes between this group and the ICDS supplementary nutrition group.

10. In each Anganwadi about 20-30 children attending the AWC on the day of the team's visit, were clinically assessed for nutritional status, by recording the weight and a general examination, for prevalence of nutritional deficiency and general health problems. Children for assessment were selected at random including proportionate numbers of children in the 1-3 and 3-6 age group). A total of 217 children attending the anganwadis were assessed.

11. In each district, schools implementing the Mid-day Meal Programme and those not implementing the Programme were visited. For this, the schools which were in the vicinity of or enroute to the anganwadi villages selected were visited. These schools were atleast 10 kms from Taluk Headquarters and therefore likely to be representative of the







situation in the peripheral areas of the taluk. The status of implementation of School Mid day Meal Programme was assessed in the taluk and the schools, the school children of Class I - IV were also interviewed and clinically assessed for nutritional status. A total of 338 children were subjected to nutritional assessment by weight, height and general examination for specific nutritional deficiency signs - 156 in the mid-day meal schools, 119 in the non-mid-day meal schools, and 63 in one school of Raichur district which was implemented only during 1990 - 91 and therefore excluded from analysis.

#### IV. EXCEPTIONS TO THE ABOVE METHODOLOGY

12. Exceptions to this methodology were as follows:

a. In Chittapur taluk, owing to inaccessibility of one of the selected villages due to rains and unjeepable road, the team could not carryout the household survey in Tengli village.

b. In Lingsugar taluk, owing to the prevailing diesel scarcity during the field visit, one of the villages selected (Jalibenchhi) was only 6 km away from Headquarters. However, it was 4 kms away from the last bus stop and the road itself was barely jeepable, and therefore this anganwadi was rarely supervised.

c) In Lingsugar taluk, one of the schools with Mid-day Meal Programme which was selected, turned out to have introduced this Programme in 1990-91, and therefore could not be unequivocally classified as either a Mid-day Meal school or non-mid-day Meal School. Findings of this school are separately presented.

13. Two voluntary agencies with concrete programmes in the areas of health and nutrition were visited in Raichur District. In Gulbarga district the Anganwadi Training Centre which is a voluntary agency was visited.

#### V. TALUKS AND INSTITUTIONS VISITED

14. The taluks, villages, schools and voluntary agencies were visited and field work carried out during November 17th to 27th, 1990. These are as follows:







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A. Gulbarga District

i) Taluks Selected:

Afzalpur (54 Km from Headquarters)  
Chittapur (55 Km from District Headquarters), and  
Sedam (55 Km from District Headquarters)

ii) Villages Selected:

a. Afzalpur : Ballurgi : 10 Kms from Taluk Headquarters  
Karajgi : 21 Kms from Taluk Headquarters  
b. Chittapur: Mullkod : 34 Kms " "  
Tengli : 45 Kms " "  
c. Sedam : Chandapur : 26 Km from " "  
Batgera-K : 10 Km from " "

iii) Schools visited: (all Government Schools)

a. Government Kannada H P School, Karajgi: Mid-day Meal Programme  
b. Government Urdu Primary School, Karajgi: Mid-day Meal Programme  
(Afzalpur Taluk)  
c. Government Primary School, Gourbi : No Mid-day Meal Programme  
d. Government Primary School, Batera-K : No Mid-day Meal Programme  
(Sedam Taluk)

iv) Voluntary Organizations visited

a. Anganwadi Training School, Gulbarga  
b. Family Planning Association of India, Gulbarga Branch

B. Raichur District

i. Taluks Selected:

Deodurg (60 Km from District Headquarters) and  
Lingsugar (98 Km from District Headquarters)

ii. Villages Selected

a. Deodurg : Chinchodi : 23 Km from Taluq Headquarters  
Hemmanur : 32 Kms from Taluk Headquarters  
b. Lingsugar: Jalibenchi : 6 Km from Headquarters (4 Km away  
from last bus stop point)  
Hanumanagudd: 26 Km from Headquarters







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*iii. Schools Visited*

- a. Government Higher Primary School, Gorebal: Mid-day Meal Programme (Lingsugur Taluk)
- b. Government Higher Primary School-Hemmanur:Mid-day Meal Programme
- c. Government Primary School, Chinchodi: No Mid-day Meal Programme
- d. Government Lower Primary School, Gorebal Thanda: No Mid-day Meal Programme (Deodurg Taluk)
- e. Government Higher Primary School, Hanumangudda:Mid-day Meal started in June 1990, not included in analysis. (Lingsugur Taluk)

*iv. Voluntary Agencies*

- a. "Samuha", Jalahalli Post, Deodurg Taluk, Raichur
- b. Family Planning Association of India, Raichur Branch







## CHAPTER - IV

## STUDY FINDINGS ON PROGRAMMES IMPLEMENTATION

*This chapter presents the findings of the Study on the present status of implementation, and issues which emerged in each of the major programmes, viz. the ICDS, Immunization Programme, Vitamin A administration programme, Prophylaxis against Nutritional Anemia in Mothers and Children, Special Nutrition Programme, School Mid-day Meal Programme, Griha-kalyana Scheme, Creches in rural areas, and scheme of financial assistance to Mahila Mandals.*

*Under the ICDS Programme, relevant information at the State level including observations and conclusions is presented, followed by information and observations at the District level, next the observations at the taluk level and Anganwadi level, and lastly, the impact observations based on the nutritional assessment of the children. A summary of the overall status and issues in the ICDS Programme in the State as a whole, and in the two Study Districts, is also provided.*

*Under the Immunization Programme, Vitamin A administration and Prophylaxis under nutritional anemia, information and observations at the State, district and beneficiary levels, is provided. Under the Special Nutrition Programme, a review at State level and the two districts is presented.*

*Under the School Mid-day Meal Programme a brief review of the programme at State level is presented, followed by review at the Taluk level and findings of nutritional status of children in the schools. Based on these findings, major issues in the programme are discussed.*

*A brief review of the three schemes for socio-economic development of women is provided.*







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## I. INTEGRATED CHILD DEVELOPMENT SCHEME

### I. Progress of Implementation at State Level

1. The progress of implementation of ICDS programme in the State is shown in Table - 9. Starting with one Project in 1975-76 on a pilot basis in T.Narsipur, by 1989-90, 108 projects were fully functional. There has been a steady expansion of the scheme with the result that, of 183 taluks in the State, 108 had functioning ICDS projects, reflecting the commitment of the State and Central Government to the Programme (An additional 28 projects were sanctioned by the Central Government in 1989-90 but due to financial constraints to bear the State's share of 60% of cost, namely on supplementary nutrition, the State did not clear it. However, during 1990-91, these projects have been cleared.) By 1990-91, 136 taluks or about 74% of total taluks would be implemented which is a major step forward in the Programme.

2. Of the 108 Projects, 58 projects are being assisted by CARE and 50 projects are being implemented without CARE assistance. (Table 9 -A). The 58 Projects being provided supplementary nutrition by CARE are limited to the more northern districts namely, all the districts of Gulbarga Division and the northerly located districts of the other divisions. These districts were presumably selected for the convenience of the CARE administration functionaries for supervision of ICDS as well as the School Mid-day Meal Programme which is also being widely implemented with CARE assistance in these same districts.

### II. Coverage of Taluks

3. One indicator of efficiency of Programme implementation would be, the proportion of ICDS Projects started in needy areas, keeping in view the general backwardness, lower socioeconomic development of the area and predominance of agricultural activities, particularly rain-fed agriculture. Table 10 shows the distribution of Projects in the different divisions. Gulbarga division is the most backward of all divisions and the highest taluk coverage is in Gulbarga Division twentyfour out of thirtyfour taluks are covered (about 66%) as compared with Belgaum Division 46% coverage of taluks, Bangalore Division 60% covered and Mysore Division 65% covered. Among the Divisions, it is noted that higher taluk coverage and also appropriate (more backward) taluks are covered in the more socioeconomically backward rather than the advanced districts. (Appendix - I -- List of Projects in Karnataka State) . This indicates that, by and large, the norms for selection of taluks for ICDS implementation are being generally followed:







4. There are a few instances of very backward taluks not being covered and instead, preference given to more taluks, such as, advanced Molkalimuru taluk of Chitradurga district would rank with the poorest taluks in the State and certainly so in Chitradurga District. So far, since 1975, it has not been selected; on the other hand, Hiriyur taluk of Chitradurga though better off was selected in 82-83. Similarly, comparing between districts, out of 17 taluks in Dharwar, all of them drought-prone, only 9, or 50% so far have been brought under ICDS coverage, whereas in Dakshina Kannada, which is among the most advanced districts, 7 out of 9 are under ICDS, many of them showing very low prevalences of malnutrition, and also reported to be having lower beneficiary utilization on the average per Anganwadi.

5. Considering Gulbarga district, it is considered to be the most backward in the State and with the highest level of child malnutrition in the State (as found by the NIN studies). In keeping with this picture, 100% of taluks are under ICDS. In Raichur, the four taluks being presently covered are also the backward ones with little (Lingsugur) or no irrigation at all. Therefore, these two districts are

Table - 9

**Progress of Implementation of ICDS Programmes Since 1975  
in Karnataka State**

Year	Number of Projects Sanctioned			Cumulative Total
	Central sector	State sector	Total	
1975-76	1	-	1	1
1976-77	-	2	2	3
1977-78	-	6	6	9
1978-79	4	6	10	19
1979-80	3	1	4	23
1980-81	3	-	3	26
1981-82	6	-	6	32
1982-83	14	15	29	61
1983-84	17	-	17	78
1984-85	-	By Saturation	-	-
1985-86	8	-	8	86
1986-87	8	-	8	94
1987-88	No Projects were sanctioned.....			
1988-89	14	-	14	108
<b>Total</b>	<b>78</b>	<b>30</b>	<b>108</b>	







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Table 9-A  
Districts Receiving CARE Assistance

Districts	Number of Projects	
	State	Central
<u>CARE Districts</u>		
1. Belgaum	1	2
2. Bidar	1	4
3. Bijapur	2	3
4. Raichur	1	3
5. Dharwar	2	7
6. Chitradurga	1	6
7. Gulbarga	3	7
8. Bellary	1	4
9. Shimoga	2	3
10. Hassan	1	3
CARE Total	15	43
<u>Non-CARE Districts</u>		
11. Bangalore (R)	-	2
12. Bangalore (U)	2	2
13. Kolar	1	6
14. Tumkur	3	4
15. Mandya	2	2
16. Mysore	-	7
17. Chickmagalur	2	2
18. Kodagu	1	2
19. U. Kannada	2	3
20. D. Kannada	2	5
Non-CARE Total	15	35
Grand Total	30	78





Divisions/  
Districts

Total No. of  
Taluks

Total No. of  
Tqs covered  
by 1989 - 90

Total District  
Popn. in lakhs  
by ICDS 1989-90\*\*

No. of Function-  
ing Anganwadis

(1981 Census)

No. in lakhs

%

### I. Gulbarga Division

1. Bellary	9	5	14.89	7.13	47.9	703
2. Bidar	5	5	9.96	8.58	86.1	848
3. Gulbarga	11	10**	20.81	13.34**	64.1**	1039
4. Raichur	9	4	17.84	5.71	32.0	589
	<u>34</u>	<u>24</u>				

### II. Belgaum Division

1. Belgaum	11	3	29.80	5.35	17.9	535
2. Bijapur	11	6	24.02	8.31	34.6	830
3. Dharwar	17	9	29.45	14.02	47.6	1387
4. Uttara Kannada	11	5	10.72	3.17	29.6	446
	<u>50</u>	<u>23</u>				

### III. Mysore Division

1. Chickmagalur	7	4	9.12	3.13	34.3	397
2. Dakshina Kannada	9	7	23.77	9.71	40.8	1164
3. Hassan	8	4	13.57	5.97	44.0	1592
4. Kodagu	3	3	4.62	2.80	60.1	508
5. Mandya	7	4	14.18	5.87	41.4	586
6. Mysore	12	7	25.96	15.40	59.3	1187
	<u>46</u>	<u>29</u>				

### IV. Bangalore Division

1. Bangalore (R)	8	2				400
2. Bangalore (U)	5	4				626
3. Chitradurga	9	7	17.77	8.46	47.6	1173
4. Kolar	11	7	19.05	8.84	46.4	1195
5. Shimoga	9	5	16.57	8.83	53.3	886
6. Tumkur	11	6	19.78	7.28	36.8	1001
	<u>53</u>	<u>31</u>				

Grant Total

183

107\*

371.36

141.9

38.2

15692

\* Information on one project was not available

Actual functioning are 108 projects

Information on Population covered by 1987-88 only.

In 1988-89, additional projects were sanctioned whose population

coverage figures were not found

28 Projects sanctioned by Government of India but not yet operational by 1989-90.



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well served as far as sanctioning of Projects in the much needed areas is concerned.

6. Overall, at the State level and in the two Districts, it can be concluded that the selection of taluks for ICDS implementation is largely as per guidelines. This signifies the commitment of the Government to improve the nutritional status and child development of the most disadvantaged, on a preferential basis.

7. ICDS Projects in the Backward Taluks: In the State, overall there are 30 State Sector Projects in which case the number of Anganwadis is limited to 100 serving a population of One lakh only. The very philosophy of starting State Projects is to take up needy areas under ICDS, which could not be accommodated among the limited number sanctioned each year by the Central Government, but nevertheless the local conditions warrant taking up the ICDS Programme. With this view many State Sector Projects have been taken up, most of them as early as 1977-78. However, once taken up, they continue to be under State Sector, and better off talukas are selected for central Sector with optimum population coverage whereas the coverage has remained at one Lakh in State Sector Projects even though majority of these are very backward and thickly populated, and even though most of these Projects would greatly benefit from the increased coverage and liberal inputs facilitated by Central Assistance.

### III. Population Coverage

8. The aim of ICDS is to improve nutritional status and child development in the State. The actual impact it can potentially make would be limited to the population covered. So far the ICDS has covered 38.2% of the 1981 census population (Table 10). (considering the additional projects for which information is not available, it may be around 50%) Considering a population growth rate of 2% per annum, the actual population coverage for ICDS as in 1988-89 would be around 31.8% (or around 40% including Projects for which information is not available).

9. Therefore, considering the population yet to be covered by suitable expansion of Projects with more Anganwadis and starting new projects, a daunting 50-60% is yet to be covered. This observation also emphasizes that the observed improvements initiated by ICDS can be extrapolated only to 30-35% (or maximum 50% including the Projects for which information was not available), of the existing population in the different districts. This is indicated in Table -10. Even by this index of population covered, it is an encouraging feature that the backward districts, notably Gulbarga, are covering highest proportion of District population under ICDS. Thus, although only about 40-50% of population is being covered by ICDS in the State as a whole, one could infer that this population probably includes the most needy







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population in the State.

10. Coverage of mother and child beneficiaries: An anganwadi centre (AWC) is expected to cover about 100 beneficiaries for supplementary nutrition (namely 80 child beneficiaries and 10 each of pregnant and lactating mothers). The sanction for number of Anganwadis is based on the 1981 census. One would expect that, with increase in population in the same village, the existing anganwadis would be overutilized (more than 100 beneficiaries) or atleast saturated. However, the average number of beneficiaries (including mothers and children) in the State per anganwadi has been 76 in the CARE districts and 66 in non-Care taluks. These figures have been more or less constant for several years.

Table - 11  
Total Number of Beneficiaries Targetted and Covered in Karnataka State

	Total Anganwadis		Beneficiary Coverage			
	1989-90		1988-89		1989-90	
Districts	Aws Sanc- tioned	Function- ing	Target	Achieve- ment	Target	Achieve- ment
CARE Districts	9181	8586	6,90,143	90%	7,48,249	87%
Non-CARE Districts	7510	7106	4,81,863	92%	5,77,273	81%
Total CARE & Non-CARE	16691	15692	11,72,006	91%	13,25,522	85%





Table -12  
Shortfall of Target Achievement for Supplementary Nutrition  
in Different Age Groups (1989-90)

S.No. Districts	Annual Target					Annual Achievement				
	0 - 3	3 - 6	PW	LM	Total	0 - 3	3-6	PW	LM	Total
<u>CARE Districts</u>										
1. Gulbarga	45322	51733	7292	6930	111277	36972	37458	5127	4858	84415
2. Raichur	24035	21805	3140	3100	52080	20367	21577	2955	2931	47830
3. Belgaum	20360	17454	2511	2516	42841	15888	17529	2085	2119	37621
4. Bellary	29858	25214	3674	4055	62801	23918	26174	3239	3276	56607
5. Bidar	30528	35418	5088	5088	76122	29029	28822	3829	3245	64925
6. Bijapur	34599	34508	4713	4713	78493	26668	31492	3805	4375	66340
7. Chitradurga	48437	37661	5743	5919	97760	27911	34828	4423	4248	71420
8. Dharwad	53731	49308	7143	7223	117405	46526	56437	6771	6889	116623
9. Hassan	20505	17760	2960	3085	44320	17623	20132	3127	3070	43952
10. Shimoga	33390	23280	4240	4240	65150	24188	33054	3162	3067	63471
Total	340725	314141	46514	46869	748249	269090	307503	38523	38088	653204
<u>Non-CARE Districts</u>										
11. Bangalore(R)	14396	13057	1765	2013	31231	12089	13602	1705	1900	29296
12. Bangalore(U)	23339	22528	3247	3594	52708	13888	12880	1822	2174	30764
13. Chickmagalur	12569	11257	1531	1784	27141	6263	8363	987	1129	16742
14. D. Kannada	38254	40932	5842	5822	90850	36864	30671	4798	6364	78697
15. Kodagu	13825	16775	2485	3152	36237	11846	11021	2167	2379	27413
16. Kolar	39566	36878	5932	6128	88504	27085	27115	4179	4515	62894
17. Mandya	20599	21833	3314	3712	49458	19176	21525	3753	3826	48280
18. Mysore	37650	38900	5550	5800	87900	36437	39141	5585	5515	86678
19. Tumkur	41746	34834	5683	5977	88240	27723	31827	4188	4703	68441
20. U. Kannada	11264	10395	1507	1838	25004	9286	9479	1407	1648	21820
Total	253208	247389	36856	39820	577273	200657	205624	30591	34153	471025
CARE + Non-CARE Total	593933	561530	83370	86639	1325522	469747	513127	69114	72241	1124229







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11. Table-11 indicates the total number of beneficiaries in 1988-89 and 89-90. A total of 6,35,204 beneficiaries (or 87% of targetted) were covered in the CARE Districts and 4,71,025 beneficiaries (or 81% of targetted) were covered in the non-CARE Districts, in 1989-90. Together with the observations made in the previous paragraph, this suggests that the targets are being fixed at slightly less than the optimum figure of 100 per Anganwadi. Also, a further analysis of the shortfall occurring at the field level suggests that specific population/age subgroups are not readily utilizing the services of the AWCs. Table 12 shows that the shortfall in most districts is maximum with respect to 0-3 years age group, pregnant women and lactating mothers. This suggests that these groups are difficult to mobilize for the Programme and hence the need for a strategy to ensure utilization of services by these groups.

12. Considering Gulbarga and Raichur districts specifically, the shortfall of achievement as against target of beneficiary coverage was to the extent of 25% i.e. 75% coverage was achieved in 1989-90. In Raichur, the coverage was 91%, more than the CARE Districts average. In Gulbarga District, the shortfall of 3-6 age group (the group which tended to utilize the services better in the other districts) was also quite high. i.e. even in this group the achievement was only about 75% (37458 served against targetted 51733), suggesting that problems of implementation was a prominent factor in Gulbarga rather than community factors.

13. A second factor responsible for shortfall of target achievement comes from unfulfilled targets in the newly operational projects which are being added every year. In these projects, targets for beneficiaries are fixed but actually the process of beneficiary identification and inclusion is going on; anganwadi workers are under training and therefore many anganwadis are closed. Thus utilization is normally expected to be low in the initial year/years.

14. Taking into account the above mentioned factor, and the community factors regarding attendance of 0-3 age group children and pregnant & lactating mothers, overall, the beneficiary coverage and utilization appears satisfactory in most of the districts. However, targets should be fixed higher, as per ICDS norm.

15. Considering the average number of feeding days, for most of the years, the average number of feeding days was optimum or almost optimum, being 24-25 days per month in most of the non-CARE districts and in most of the CARE districts 23 - 24 days. (Table not presented). Thus number of feeding days has been satisfactory.

Overall, it could be estimated at the State level, that delivery of supplementary nutrition under ICDS in the State as a whole was satisfactory.







#### IV. Budgetary Allocation and Utilization

16. The budget allocation for the Districts has been increased year by year, commensurate with the expansion of the Programme and increase in number of targetted beneficiaries. The budget makes provision of Re.0.50 per beneficiary in Non-CARE Districts and the Re 0.14 per child in CARE districts. Table 13 gives the district-wise budget allocation and expenditure for supplementary nutrition in the last three years. The district-wise budget utilization on supplementary nutrition shows a great deal of shortfall particularly in few districts. At the State level, the utilization in 1987-88, 88-89, and 89-90 were respectively, 78%, 65%, and 65%. The shortfall in achievement of beneficiary coverage does explain part of the shortfall. The remaining gap in utilization implies a decreased expenditure on food per beneficiary, which indicates that perhaps quality of food served has not been as provided for.

17. The Supplementary nutrition is being costed very carefully, and even so, the amount of Re.0.50 per beneficiary in non-CARE and 0.14 in CARE areas, is considered to be inadequate since it was fixed in 1984-85 and prices have risen a great deal since then. Therefore, for optimum service delivery, there should be maximum budget utilization to deliver nutrition of good quality, taste and acceptability.





Allocation and Expenditure for Supplementary Nutrition  
Districtwise during 1987-88 to 89-90

(Rs. in lakhs)

Sl.No. District	Allocation			Expenditure		
	1987-88	1988-89	1989-90	1987-88	1988-89	1989-90
<b>I CARE Districts</b>						
1. Gulbarga	67.70	64.00	67.72	39.65	33.10	27.29
2. Raichur	21.62	40.82	47.50	25.14	26.54	30.72
3. Bidar	31.35	47.56	49.74	36.00	28.27	25.05
4. Bellary	23.95	50.00	57.18	22.63	25.16	21.17
5. Bijapur	30.00	44.74	45.68	29.84	31.30	34.95
6. Dharwad	49.30	71.25	74.20	43.55	46.16	49.80
7. Shimoga	46.70	52.50	50.50	34.21	33.38	29.00
8. Belgaum	19.15	41.80	46.18	20.57	17.84	14.01
9. Hassan	76.80	72.00	57.00	53.14	32.62	16.33
10. Chitradurga	43.50	52.50	57.00	26.50	23.60	33.15
<b>Total I</b>	<b>410.07</b>	<b>537.17</b>	<b>552.70</b>	<b>331.23</b>	<b>297.98</b>	<b>281.47</b>
<b>II. Non-CARE Districts</b>						
11. Bangalore (U)	42.55	147.00	147.00	48.39	47.70	45.80
12. Bangalore (R)	57.25	56.65	57.65	41.48	43.96	53.76
13. D.Kannada	105.80	93.30	72.00	52.74	83.04	91.76
14. U. Kannada	30.10	30.80	36.00	25.90	26.59	26.70
15. Chickmagalur	34.95	35.70	39.70	20.73	22.56	20.86
16. Tumkur	84.40	112.00	123.00	87.70	104.15	99.52
17. Mandya	75.60	84.00	87.00	78.21	57.72	62.94
18. Kodagu	47.60	39.75	42.00	25.00	29.69	37.68
19. Mysore	116.95	117.74	135.00	97.02	95.99	101.83
20. Kolar	91.28	75.70	85.00	64.04	68.19	75.96
<b>Total II</b>	<b>686.48</b>	<b>792.64</b>	<b>824.35</b>	<b>542.21</b>	<b>579.59</b>	<b>616.81</b>
Head Office	100.00	100.00	100.00	62.00	62.62	69.97
State Level	1196.55	1429.81	1477.05	935.44	944.19	968.25
				(70.2)	(65.8)	(65.6)

Note: Figures in brackets indicate % of Expenditure to allocation for the State as a whole.



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18. Table 14 shows the actual expenditure per beneficiary covered in CARE and non-CARE districts during 1989-90. The actual expenditure per beneficiary per day in 1989-90 ranged from Rs.0.28 in Dakshina Kannada District (Non-CARE) to Re.0.55 in Bangalore (Rural). Even in CARE districts, where Re.0.14 for condiments and pulses is considered quite inadequate, the actual expenditure per child ranged from 0.10 in Gulbarga to Rs.0.19 in Raichur. Thus expenditure per beneficiary has been below the provision in several districts.

This suggests that Programme management factors relating to timely release of funds or timely purchase of commodities may have been responsible for decreased expenditure per beneficiary served.

19. Looking at the pattern of ICDS administrative budget allocation and expenditure, it was found that there was shortfall of utilization of the order of 10-20% in most districts, but in Gulbarga the shortfall of utilization was substantially more than in most other districts. The budget allocation and expenditure of administrative costs are indicated in Table 15.

20. Annual cost to the Government per Beneficiary: The annual cost to the State per beneficiary in 1989-90 is worked out in Table 16; in the CARE districts this worked out to Rs.133.32 and in the non-CARE districts, it worked out to Rs.208.61. The cost differential between CARE and non-CARE beneficiaries considering only food items is quite high, being Rs.38.57 per beneficiary in CARE districts and Rs.115.13 per beneficiary in non-CARE districts.

21. Overall, the situation with regard to budget allocation and expenditure shows that, the State Government is firmly committed to the ICDS programme, and every year, adequate financial resources are being made available, whether from the State sector expenditure or Central Sector. At this stage, the critical factor which can improve the services delivery further is, improved management inputs and strategies for better budgetary utilization, better beneficiary coverage, particularly of the 0-3 age group, and mothers, and possibly, towards more efficient utilization of resources being spent, at the field level.







Table - 14  
Districtwise Information on Expenditure on Supplementary Nutrition per  
Beneficiary in CARE and Non-CARE Districts during 1989-90

Sl.No. District	No. of Beneficiaries covered during 1989-90 for Supplementary Nutrition		Expenditure on SNP Under ICDS (Rupees in lakhs)	Expenditure per beneficiary.(1 mother = 2 children units,for 300 feeding days in a year (in Rs./day)
	Children below 6 years	Pregnant/ Lactating Mothers		
I. CARE Districts				
1. Gulbarga	74430	9985	27.29	0.10
2. Raichur	41944	5886	30.72	0.19
3. Bidar	57851	7074	25.05	0.12
4. Bellary	50092	6515	21.17	0.11
5. Bijapur	58160	8180	34.95	0.16
6. Dharwad	102963	13660	49.80	0.13
7. Shimoga	57242	6229	29.00	0.14
8. Belgaum	33417	4204	14.01	0.11
9. Hassan	37755	6197	16.33	0.11
10. Chitradurga	62739	8681	33.15	0.14
Total	5,76,593	76,611	281.47	0.13
II. Non-CARE Districts				
11. Bangalore (U)	26768	3996	45.80	0.44
12. Bangalore (R)	25691	3605	53.76	0.55
13. D.Kannada	67535	11162	91.76	0.34
14. U. Kannada	18765	3055	26.70	0.28
15. Chickmagalur	14626	2116	20.86	0.37
16. Tumkur	59550	8891	99.52	0.43
17. Mandya	40701	7579	62.94	0.38
18. Kodagu	22867	4546	37.68	0.39
19. Mysore	75578	11100	101.83	0.35
20. Kolar	54200	8694	75.96	0.35
Total	4,06,281	64,744	616.81	0.38
	9,82,874	1,41,355	898.28	0.24
Administration			69.67*	

\* Refers to administrative and transportation costs of CARE Programme







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Table - 15  
ICDS Expenditure on Administration, 1989-90

S.No.	District	Allocation (Plan + non-plan) (in lakhs)	Expenditure (Plan + non-plan) (in lakhs)
Care District			
1.	Gulbarga	106.22	67.41
2.	Raichur	53.43	43.64
3.	Bidar	80.29	63.84
4.	Bellary	59.99	45.04
5.	Bijapur	84.40	68.63
6.	Dharwad	121.43	109.31
7.	Shimoga	77.68	64.05
8.	Belgaum	45.49	37.87
9.	Hassan	46.64	41.04
10.	Chitradurga	105.11	71.71
Total		779.68	612.54
Non-CARE Districts			
11.	Bangalore (U)	48.80	37.17
12.	Bangalore (R)	33.00	28.51
13.	D. Kannada	102.50	75.53
14.	U. Kannada	38.14	30.29
15.	Chikmagalur	35.18	25.37
16.	Tumkur	89.37	66.70
17.	Mandya	49.97	42.76
18.	Kodagu	40.76	28.27
19.	Mysore	82.66	67.14
20.	Kolar	10.00	7.80
Total		628.38	500.88
CARE plus Non-CARE Total		1408.06	1113.42







Table 16  
Average Cost to the State Per Beneficiary, 1989-90

Sl.o.	Item	CARE Dists.	Non-CARE Dists
(Rs in lakhs)			
1.	Expenditure on Food Items	281.47	616.81
2.	Administrative Expenditure in the districts	612.54	500.88
3.	Transportation cost of CARE food and CARE administration Cost	69.67	-
Total		972.98	1117.69
4.	No. Of Beneficiary unit in the year	729815	535769
5.	Annual Cost per beneficiary (food + Administration cost)	Rs. 133.32	Rs. 208.61
6.	Annual Cost of food per beneficiary	Rs. 38.57	Rs. 115.13
7.	Total cost/beneficiary (CARE & Non-CARE Districts)	Rs.165.19	

#### V. Availability of Staff and Infrastructure

22. The ICDS scheme is a Programme in which men and materials are both equally crucial to the success of the Programme. Being a Programme reaching out to the remotest village, the organizational structure, both in quantity and quality at every level, would greatly influence the proper utilization of resources for achievement of the Programme objectives, namely reduction in child malnutrition, non-formal education to prime the child for school, convergence of optimum health services to the child.

23. The organizational structure of the ICDS is as follows: At State level, the Director of Women and Children's Welfare is overall in charge of the Programme, assisted by one Joint Director (ICDS), one Assistant Director, Programme Officer, and ministerial and other staff. The State administration is the sanctioning authority for Projects, budgets, personnel, and to provide monitoring, supervision, and technical and management inputs to the Districts.

24. At District level, the key person is the Assistant Director of Women and Children's Welfare, who is responsible for management and implementation of all Programmes under the Department, including ICDS. The administrative authority for sanction of funds to the Assistant Director is the Zilla Parishad.







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25. At the taluka level, the key to the success of the Programme is the Child Development Project Officer along with Supervisory staff. The CDPO is a post-graduate in Social Work, psychology, nutrition or related subjects; trained for the ICDS Programme at the National Institute of Public Cooperation and Child Development, and he is responsible for Project Planning (at the beginning of a Project), organizing, financial matters, monitoring and supervision, and reporting to the District level, for the entire ICDS Project in one taluk. In large taluks with 150 or more AWCs, he is also assisted by one or two Assistant CDPOs. The CDPO is assisted by Anganwadi Supervisors, appointed one for every 20 AWCs, who are responsible to visit every Anganwadi at least once a month, supervise the Anganwadi including and utilization of materials, provide technical and skills guidance, promote cleanliness and discipline among the Anganwadi Workers towards proper discharge of their functions. The service of the Anganwadis are broadly indicated in Chapter - I.

26. Adequacy of key staff, particularly field officers, and staff is crucial to the success of ICDS Programme in a district. The proportion of staff in position in the districts is indicated in Table 17. (Staff was being sanctioned as per norms in all districts). Seventeen of the expected posts of 20 Assistant Directors in the Districts were filled. Thus in three districts, a Child Development Project Officer was in charge, of the AD's post, looking after the District level functions, as well as the ICDS Project. The district-wise staff position in the State with regard to CDPOs and anganwadi supervisors was not satisfactory - 68% post occupancy of CDPOs, ACDPOs - 90% and Supervisors 72%.

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Table - 17  
Proportion of Sanctioned Staff in Position-District-Wise

S.No.	Districts	Proportion of Sanctioned Staff in Position (% of Sanctioned)		
		CDPOs	ACDPOs	Supervisors
1.	Bangalore - U	80%	100%	100%
2.	Bangalore - R	50%	100%	90%
3.	Chitradurga	86%	100%	61%
4.	Gulbarga	81%	88%	36%
5.	Dakshina Kannada	75%	75%	98%
6.	Dharwad	81%	67%	98%
7.	Kodagu	100%	60%	75%
8.	Mysore	78%	86%	86%
9.	Mandya	20%	100%	79%
10.	Kolar	70%	100%	69%
11.	Bellary	67%	100%	60%
12.	Belgaum	33%	100%	96%
13.	Uttara Kannada	33%	-	100%
14.	Shimoga	67%	100%	100%
15.	Chickmagalur	60%	100%	70%
16.	Hassan	50%	100%	80%
17.	Bijapur	75%	100%	77%
18.	Bidar	100%	100%	37%
19.	Raichur	50%	100%	37%
20.	Tumkur	78%	100%	25%
		68%	91%	72%

27. Considering Gulbarga and Raichur Districts, the proportion of CDPOs in position was 81%, and in Raichur it was 75% (in fact the favourable staff position of CDPOs was temporarily achieved in 1989-90-91 due to the former Chief Minister's intervention to post officers to these districts since he hailed from that area). In respect of supervisors, it was highly unsatisfactory - 32% were in position in Gulbarga and 60% in Raichur.

At Anganwadi level, there is no serious shortage of personnel. (It is seen from Tables 10 and 11 that most of the AWCs targetted are functioning in all districts.)

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## VI. Training

28. Regarding training, there has been no problem to send the officials and Anganwadi Workers for required training since adequate training facilities and budgets are available. Reorientation training for anganwadi workers is also reported to have been given to most of the workers during the first two-three years after initiation of the Project.

29. Anganwadi Training Centres managed by Voluntary Organizations have been providing the three-month training to Anganwadi workers. There are 25 Centres in the State, well distributed all over the State. The training facilities in term of quantity as well as quality of training imparted, were felt to be satisfactory both at State level as well as by the officers of Gulbarga and Raichur Districts.

## VII. Intersectoral Coordination

30. The ICDS Programme envisages close coordination between the ICDS functionaries and the Health Department functionaries - the Anganwadi worker with the Health Workers (Female), and the Supervisors and CDPOs with the PHC Medical Officers. The Programmes being carried out by the Health Department which are envisaged to be facilitated by the Women and Children Welfare Department are:

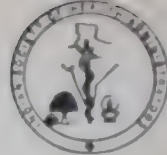
- i) Immunization Programme
- ii) Vitamin A Prophylaxis against Nutritional Blindness in Children aged 1-5 years
- iii) Prophylaxis against Nutritional Anemia in Pregnant Mothers and Children

Apart from liaison between the PHCs and Anganwadi Workers to ensure coverage of children in these programmes, the Medical Officer is expected to visit every Anganwadi Centre in the PHC area once in three months for health checkup, identification of severe malnutrition, and other health problems, as well as treatment or referral.

31. In practice, intersectoral coordination does not appear to have taken off as expected. The tables presented in the Review of Immunization Programme showed that, except in districts where UIP was in operation in the respective years, there was no difference in immunization coverage in the ICDS vis-a-vis non-ICDS Taluks. (Tables 28 A & B). However, it has to be kept in view that the figures of achievement were found to be far from the actual vaccination coverage found in most Districts by the UIP Immunization surveys and therefore it is difficult to draw any definite conclusion at the State level regarding the role of ICDS prior to UIP.







A tentative comparison of performance under Vitamin A administration in the ICDS taluks as compared with non-ICDS taluks showed no consistent difference, between the two groups, in any of the districts. (Table 31)

32. The frequency of visits of Medical Officers to the Anganwadi Centres needs much improvement (table not presented). It was particularly so in the two districts of Gulbarga and Raichur. However, during the current year, particularly since September 1990, the frequency of visits of MOs in Gulbarga and Raichur Centres was reported to have increased because of massive mobilization and pressure to achieve targets under the Universal Immunization Programme.

33. It was generally observed in both Districts, that CDPOs, Supervisors and Anganwadi Workers were emphasizing and concerned about immunization programme. In fact, CDPOs vehicles are being readily offered and extensively used by the Medical Officers for immunization camps.

34. The general observation of the study team was that most of the Anganwadi workers, and supervisors of the Projects studied were not very much aware of the importance, nor emphasizing enough on the Vitamin A administration or anemia prophylaxis Programme. Also, since the recording, reporting and monitoring system under ICDS does not include monitoring of these aspects, these programmes receive far less attention than the feeding activity and immunization.

#### VIII. Impact of ICDS - Trends in Nutritional Status of Children in the ICDS Project Areas in the State

35. Nutritional status of children enrolled for special nutrition is being regularly assessed by weighing the children monthly at the Anganwadi. With the assistance of the growth chart, the AWW classifies the children as normal nutrition, or mild, moderate or severe malnutrition. This information is reported to the concerned Primary Health Centres as well as to the CDPO's office through the monthly report. The PHCs in turn, compile the information from all anganwadis in their area, and report to the State Directorate of Health and Family Welfare, where the information is compiled Projectwise by the Nutrition Monitoring Cell. Based on the data available from 1986-87 upto 1989-90, the Division and district-wise conclusions regarding impact have been made. The general observations on reliability of the reported figures and State-wide trends are reported in the Appendix.

36. The divisionwise observations on nutritional status during 1986-87 to 1989-90 are presented in subsequent paragraphs. The data on reported nutritional status in Gulbarga and Raichur Districts, as well as in two (conventionally) advanced districts - Dakshina Kannada and Hassan are presented in Tables 18(a), (b), (c), and (d).







37. Observations on Gulbarga Division: Many PHCs have not been reporting in this Division. Of 22 projects, 13 projects showed reasonable reliable figures. Moderate malnutrition could be considered to be definitely on the decline in four of the 22 Projects. Tables 18 (a), (b), (c) and (d) show the trends in nutritional status in the districts of Gulbarga, Raichur and two of the advanced districts - namely Hassan and Dakshina Kannada.

38. In none of the taluks of Gulbarga (even those started 8-10 years back) are the levels of moderate malnutrition reported below 10% by 1989-90, (with the exception of Humnabad and Bhalki of Bidar District where some fluctuations from year to year are seen and needs corroboration at field level.) Sedam was the most recently started ICDS Project in Gulbarga (with reliable figures) and Deodurg the most recent one in Raichur. The reported levels of moderate malnutrition is very high in both, about 31% in Sedam, and about 30% in Deodurg (Deodurg figures are corroborated by ICDS Annual Survey 1987). Severe malnutrition figures of Deodurg are low compared with survey figures but still on the higher side. Considering these two taluks as base line or control figures in these districts one can infer that the situation has improved in the other ICDS taluks with 6-8 or more years of Project implementation.

39. Afzalpur taluk in Gulbarga district shows better nutritional status during 1987-89 as compared with Sedam, Chittapur and Jewargi appear to be quite poor compared with Afzalpur, and more similar to Sedam in spite of 13 years and 7 years respectively of the project being implemented. The reported figures from the former two taluks showed quite bizarre pattern from year to year, and one cannot rely much on these figures. Maximum improvement was observed in Yadgiri as per reported figures and all other taluks in Gulbarga District are showing highly fluctuating figures and do not appear reliable\*.

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\* The above observations were corroborated by the findings and Programme assessment during the visit to the districts of Gulbarga and Raichur. Very low supervisory post occupancy in Gulbarga district as a whole resulted in extremely inadequate supervision of anganwadis. The study team could correlate clearly between the picture of the taluk presented by the State Reports, with supervision which emerged as the single most important factor for efficiency of Anganwadi functioning and reporting. The relative unreliability of reported figures for Gulbarga District as a whole, was explained by this factor. To illustrate, Afzalpur Project of Gulbarga district showed reasonably stable figures from 86-87 to 89-90. During the visit it was found that for many reasons, Afzalpur enjoys the best post occupancy rate for supervisor level in the district. Chittapur is a State sector project. Because of very poor roads and communications, more backward situation compared to Afzalpur, and chronic low supervisory post occupancy in Chittapur (one out of 5 in position), the supervision is very low or almost nil. As a result Chittapur was found have a barely continuing feeding programme under ICDS. This status is reflected in the routine reports of the taluk showing higher levels of malnutrition, as well as markedly fluctuating figures from year to year showing unreliability of data.





Table 18 (a)  
Trends of Nutritional Status of Under-Six Children in Gulbarga District

Project	Year of Initiation	Prevalence of Malnutrition							
		1986-87		1987-88		1988-89		1989-90	
		Moderate %	Severe %	Moderate %	Severe %	Moderate %	Severe %	Moderate %	Severe %
Afzalpur	1981-82	13.73	1.74	16.3	1.8	13.42	1.92	16.78	2.34
Chincholi	1983-84	14.52	1.51	10.9	1.17	17.23	1.41	9.37	0.35
Chittapur	1977-78	12.18	0.53	19.4	1.67	27.26	1.4	18.5	2.26
Gulbarga(U)	1986-87	-	-	NA	NA	1.79	3.72	19.82	-
Jewargi	1982-83	15.9	3.03	10.3	1.64	23.35	0.35	19.27	2.12
Sedam	1985-86	NR	NR	31.9	3.36	31.7	2.68	9.36	1.29
Shorapur	1982-83	23.95	6.33	17.35	3.3	9.92	1.68	14.73	1.36
Yadgir	1982-83	19.75	2.15	13.2	2.1	13.72	1.76	12.79	1.66

Source: Progress Reports Compiled by State Nutrition Monitoring Cell, Directorate of Health and Family Welfare



Table 18 (b)

Trends of Nutritional Status of Under-Six Children in Raichur District

Project	Year of Initiation	Prevalence of Malnutrition							
		1986-87		1987-88		1988-89		1989-90	
		Moderate %	Severe %	Moderate %	Severe %	Moderate %	Severe %	Moderate %	Severe %
Kushtagi	1981-82	20.36	8.10	21.3	3.75	19.3	2.66	15.78	3.19
Lingsugur	1983-84	16.64	3.78	13.3	1.51	13.88	1.65	13.99	4.93
Yelaburga	1978-79	12.43	2.55	10.5	3.76	11.55	1.25	11.43	1.44
Devadurga	1986-87	NA	NA	NA	NA	29.5	3.38	19.76	3.49

Source: Progress Reports Compiled by State Nutrition Monitoring Cell, Directorate of Health and Family Welfare





Table 18 (C)

Trends of Nutritional Status of Under Six Children in Dakshina Kannada District

Project	Year of Initiation	Prevalence of Malnutrition			
		1986-87	1987-88	1988-89	1989-90
		Moderate % Severe %	Moderate % Severe %	Moderate % Severe %	Moderate % Severe %
Belthangdi	1982-83	31.03 0.78	19.28 1.09	26.54 1.78	21.49 1.2
Sullia	1983-84	23.16 3.55	24.06 0.33	29.37 0.14	14.27 0.13
Coondapura	1982-83	3.0 0.08	4.15 0.32	6.66 1.26	4.98 0.14
Kerkala	1982-83	3.0 0.25	5.16 0.21	4.47 0.14	4.13 0.15
Mangalore	1980-81	- -	8.54 0.24	7.36 0.18	6.62 0.23
Udipi	1976-77	7.98 0.02	9.65 0.17	6.3 0.08	8.64 0.02

Source: Progress Reports Compiled by State Nutrition Monitoring Cell, Directorate of Health and Family Welfare





Table 18 (d)  
Trends of Nutritional Status of Under Six Children in Hassan District

Project	Year of Initiation	Prevalence of Malnutrition			
		1986-87	1987-88	1988-89	1989-90
		Moderate % Severe %	Moderate % Severe %	Moderate % Severe %	Moderate % Severe %
Belur	1985-86	NR NR	35.89 1.46	25.54 0.74	16.51 0.53
Channarayana- patna	1982-83	9.59 0.56	9.78 0.68	10.2 0.46	9.34 0.31
Hassan	1978-79	17.25 0.69	15.42 0.61	12.56 0.23	13.20 0.21
Holenarsipur	1983-84	13.66 1.27	NA NA	11.97 1.94	12.53 0.84





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40. **Observation on Bangalore Division:** Data is available for 25 projects, of which data from six had to be classified as unreliable.

a. Nine of the 19 projects were continuing to show stable prevalences of moderate malnutrition in the range of about 15% during the period 1986-87 to 1989-90. This suggests that there is scope for improvement and needs further study to identify the management issues.

b. Moderate malnutrition levels were observed to be definitely on the decline in four taluks, static in 11 projects, and difficult to judge in the case of others.

c. In most of the Projects where moderate malnutrition seemed pegged at around 20%, severe malnutrition also appeared to be static remaining around the 86-87 figure. This needs detailed understanding of the factors responsible. The districts showing this features are Tumkur and Shimoga districts.

41. **Observations in Belgaum Division:** Data was available on 21 taluks of which five were considered not reliable.

a. Dharwar and Bijapur districts were continuing to show high proportion of taluks with moderate malnutrition stable over the years at high levels (around 15-25% prevalence) even though the Projects are in operation for 7-8 years or more. Also two taluks of Uttara Kannada District were showing this phenomenon. On the other hand, Belgaum district taluks tended to show a low prevalence in old projects or declining trend even in relatively recently started taluks. This finding appears to be in line with the general socioeconomic development of the respective districts.

b. Overall, 7 out of 21 showed declining trends of moderate malnutrition. It was more or less static in the remaining taluks, at quite high levels of 20-30% in some cases. However, severe malnutrition showed a clear decline in 7 of the 16 taluks.

42. **Observations on Mysore Division :** Data was available on 26 taluks of which five appeared to be of doubtful reliability.

Overall in Mysore division, the situation appeared to be best as compared with all other divisions. Only five taluks with relatively higher prevalence remained static during the period 86-87 to 89-90.

Prevalence of severe malnutrition is lowest in Mysore division, and in newly started projects, it appears to have come down rapidly. In Mysore Division, seven of the 26 taluks showed low levels of prevalence of moderate malnutrition (below 10% prevalence) compared with 5 in Belgaum Division and none in Bangalore and Gulbarga Divisions.







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43. To summarize the data on nutritional status from the Projects, it suggests that overall Project management is best in Mysore Division and poorest in Gulbarga Division, and within Gulbarga Division. Gulbarga district appeared to be the poorest performing and/or reporting in ICDS. Gulbarga district showed poor nutritional status even in many long established projects. The impact of ICDS on nutritional status appeared to be better in Raichur district in comparison with Gulbarga district. Analysis of nutritional status along with the preliminary observations and corroboration of these findings during field visit to the two Study districts suggests that, nutritional status data from Projects is a valuable aid to monitoring and assessment as to how well the Programme is functioning in the Projects, and can provide guidelines to State and district level administrators, as to which are the Projects where things are not going on well, and also, what are the probable reasons for poor performance. The data can assist in timely management interventions to correct the situation, rather than waiting for expensive time consuming surveys to give the 'exact picture' which in any case cannot be undertaken in all Projects or even a fraction of the projects on a continuous basis. However, for further validation of the potential of nutritional status data to serve as a management tool for monitoring Programme Performance, a detailed study is needed, of all Divisions in the State on similar lines as the present study of two districts.

## **B. Present Status of ICDS Programme Implementation - Review at District Level - Gulbarga and Raichur Districts:**

### **I. General Information on Gulbarga and Raichur Districts**

#### **44. Gulbarga District:**

Gulbarga district belongs to erstwhile Hyderabad Province. The salient features of the district which distinguish it from other districts are as follows:

i) **Demography:** In the 1981 Census, the District had a population of approximately 20.81 lakhs of which 77.1% rural population is very sparsely distributed. Population density is 128/Sq.Km., among the lowest in the plains of the State; similar to Raichur which has a density of 127/Sq.Km. The sex ratio is quite high compared to the rest of the State (981) whereas the state average is 916. The proportion of Muslim population in Gulbarga is among the highest in the State, being about 30%. Proportion of SC population is 21.9% (among the highest in the State, next only to Kolar which has 24.7%) and ST population of 4.7%. Thus these groups which tend to be backward in terms of literacy, income, high fertility and poor health and socio-economic status of women and children, constitute about 56% of the population.







ii) *Climatic Factors:* Very hot climatic conditions matched by very few districts (i.e. the other districts in Gulbarga Division). As a result, the majority of people of the State living in salubrious climate find it difficult to acclimatize. Hence one of the most shunned postings by Government officials is Gulbarga District.

iii) *General Socio-economic Information:* In general, the District is considered extremely backward for several reasons. Majority of the rural population who constitute 77% of the District population have their income tied closely to rainfed agriculture. Soil is fertile with black cotton soil but the area is drought-prone. Most of the urban population depend on extremely petty occupations such as rickshaw pulling, coolie work, etc. There is virtually no major factory in Gulbarga district except the Vasavdutta Cement Factory at Sedam; two large Cement factories at Shahapur, and few mini-cement plants. Apart from agriculture, the major source of income is stone quarrying and polishing. A common observation made by most of the Officers was that, stone quarrying as an industry is one of the most damaging to family and family economy since alcoholism among stone quarry and cutting workers, compared to any other category of workers is very high. Seasonal migration of workers to irrigated parts (such as parts of Sedam and Afzalpur-lift irrigation) or other districts such as Raichur (irrigated taluks of Raichur taluk, Manvi, Gangavathi and Sindanur) is very common. This factor has much relevance for coverage and impact of the ICDS programme since it is reported, as well as it was our common observation during visits of Anganwadi's that, good proportion of severe malnutrition cases, especially among under-twos who do not really recover i.e die inspite of nutrition supplementation or continue to suffer from severe malnutrition for two, three or even four years, are children of migrant workers. In the new place of migration, there appears to be a major family and health displacement such that by the time the child returns to Anganwadi, frequently, malnutrition has supervened.

The staple crop grown and consumed is jowar. Pulses notably tur, are also grown and these two items form the staple diet. Groundnut and other oilseeds are grown as cash crops. Notably, vegetables, dairy and other sources of protective foods are conspicuously absent in the agricultural scene of the district.

iv) *Literacy:* Literacy, whether of general population or females in Gulbarga, is among the lowest in the State. The general literacy at 24.9% is among the lowest (others being Raichur 24.7% and Bidar 26.4%). Rural female literacy is 7% again the lowest in the State. These factors profoundly influence maternal and child care practices, status of women and children and thereby, the maternal and child health and nutrition status, utilization of health services, family planning acceptance, etc.







v. *General Infrastructure:* Infrastructure in terms of roads, government buildings, schools, living facilities for government officials and general population, buildings in villages for community purposes such as Anganwadis or even CDPOs offices, are very inadequate. It was understood that, with the construction of living quarters under the India Population Project - III, many Programmes, even other than Health Programmes such as ICDS, may show better results in future, since officials posted atleast have a living quarter now.

Schools and colleges were very inadequate until ten to fifteen years ago. During the last decade, atleast primary schools have come up within reach of most people, though availability of high schools is still very much inadequate. Colleges are only located at taluk headquarters and many are only junior colleges.

The traditional educational backwardness of the District is attributed to neglect of building up institutions in these areas by the Nizams prior to Independence, and successive Governments of Karnataka thereafter. During the last 10-14 years, educational institutions have come up, as a result of which, it is hoped that more representation in the Government services would be from this district, who would be willing to be posted back here. (At present all officers, clerks and field cadres, who have remained in these posts for long time in the Gulbarga division are either those belonging to Bijapur district or from Gulbarga Division (Bijapur district is a neighbouring district but advanced in terms of educational development, since it was a part of Bombay Province which gave priority to education).

A case of the Health Department illustrates the point. Before the HKE Society Medical college came up in Gulbarga, very few persons from this region were educated to become doctors, since educational standards of candidates were considered to be low, and either they could not compete or afford the living expenses to study in the southernly located Medical Colleges. Since the HKE Society came up during 1972 or so, the College had a policy of reserving a proportion of seats for people of the region, and hence since the past 8-10 years, progressively the number of doctors from these areas entering government service has been increasing, and correspondingly, post occupancy in the Health Department is improving.

The educational backwardness is also reflected in low education and skills of the lower echelons of personnel in all Departments. These categories of personnel, recruited locally, are required to have certain skills and standard of education to be able to perform their duties. Whether it is Auxiliary Nurse Midwives, Lady Health Visitors, Health Inspectors of the Health Department, or the Anganwadi Workers and Supervisors of the Women and Children's Welfare Department, this constraint of human resources to carry out the Programmes is being felt.







vi) Community Characteristics Relevant to ICDS Programme:

A salient feature relating to prevalence of child malnutrition was the predominance of Lingayat Community in the two study districts. This community is purely vegetarian. Combined with low per capita consumption of pulses, particularly among children, this factor is thought to be a major factor in high prevalence of child mal-nutrition in Gulbarga and Raichur districts.

A major community characteristic which is thought to be affecting community participation and thereby better performance, is the general lack of philanthropic attitude among the people. Thus for all matters, including fuel, local building, additional condiments or vegetables to be added to the food, the village communities do not come forward to participate. Everything is expected to be provided by the Government. This was reported to be a marked contrast with Dakshina Kannada District where the community had donated buildings for the anganwadi, and participated in many ways.

A notable point with regard to availability of drinking and potable water in the two study districts is that, tremendous advances have been made during the last decade. Atleast one source of safe drinking water is available in every village.

45. *General Information on Raichur District:*

Raichur district also belonged to erstwhile Hyderabad province. In most respects it is similar to Gulbarga district. The salient features are as follows:

i) Demography and Socioeconomic Conditions:

Raichur district had a population of 14.15 lakhs in the 1981 Census of which 80.7% was rural, sparsely distributed like Gulbarga, and population density was 127 per Sq.Km. The sex ratio at 988 is higher than the State average of 96.3. The scheduled caste population is 15.1% of the total and 9.9% is tribal. Irrigation has progressed rapidly in the last decade. About 10% of the cultivable land was under irrigation in 1981 and increased rapidly; in recent years the proportion of irrigated land is about 30-40%. Irrigation is available mostly in the taluks of Manvi, Sindanur, Gangavathi and parts of Lingsugar and Raichur Taluk. In addition to irrigated land, dairy farming is quite well developed atleast for household consumption and sale in nearby towns, which is not seen in Gulbarga district. In addition to jowar and pulses which are the staple crops, substantial area is under sugarcane, cotton and paddy which serve as cash crops.

ii) *Industry* is very little developed, although agro-based business and commercial activities are well established. A total of 345 registered factories employing 9455 employees were enumerated in 1981







census. Small scale industries, mines and stone quarrying make up the non-agricultural activities in the district. Two major public sector undertakings are located in the district, the Raichur Thermal Power Plant and the Hutti Gold Mines.

iii) *Climate*: Climate is similar to that of Gulbarga.

iv. *Literacy*: Overall literacy is also similar to Gulbarga being 24.7%. Female literacy rate especially in rural areas was also similar to Gulbarga.

v. *General Infrastructure and Educational Institutions*:

During the last decade, compared with Gulbarga, the local infrastructure in terms of roads, communications, business and educational institutions, has improved due to generation of local resources following irrigation by the Upper Krishna Project.

46. The status of implementation of the programme in Gulbarga district was discussed at length with the Assistant Director Shri N S Ganjalkhed, Mr C R Jadav, Mr S B Desai, Mr S T Talwar, Child Development Project Officers in Gulbarga districts, Ms Bhagyalakshmi, Principal Anganwadi Training Centre, Gulbarga, and Mr B H Biradar, Lecturer, Social Work and Community Development, Anganwadi Training Centre, Gulbarga. In Raichur, discussions were held with Mr L K Deshpande, Assistant Director in charge and CDPO of Deodurg, Mr Rangaswamy, CDPO, Lingsugur.

The picture of ICDS in Gulbarga and Raichur districts as compared with the other districts where these officers had served previously, was also reviewed. The comparative picture of ICDS in Gulbarga and Raichur districts, in comparison with the neighbouring districts of Bidar, Bijapur, and others is also discussed.

47. *Data on ICDS Programme Implementation in the two Districts*

Information was collected on quantitative and qualitative aspects of the five components of ICDS Programme from the District-level.

A. *Expansion of ICDS*

In Gulbarga, the first ICDS Project was initiated in Chittapur taluk under the State sector in 1977-78. After that, upto 1982, no new projects were undertaken in the district. In 1982, four projects, two under Central and two in the State sector were initiated, namely, Afzalpur and Shorapur (Central), Jewargi and Yadgir (State). In 1983, Chincholi was taken up, in 1985, Sedam, 1986-87 Gulbarga (urban) were taken up, all in the Central sector. Aland and Shahapur (both Central) were sanctioned during 1988-89, but implementation was delayed and in fact Programme is yet to take off in Aland. With these all







taluks in Gulbarga district would be covered by ICDS.

In Raichur by 1989-90, totally four taluks out of nine were covered by ICDS. The first ICDS Project was Yelburga, taken up in 1978-79 in the State Sector. All others are Central Projects - Kushtagi was taken up in 1981-82, Lingsugur in 1983-84 and Deodurg in 1986-87. Except Lingsugur, where a small part is covered by irrigation, all other ICDS taluks of Raichur are dry lands and drought-prone.

Raichur and Manvi have been selected for implementation during 1989-90 but implementation is not yet taken up and is expected to be completed in 1990-91.

*B. The population coverage in most of the taluks of Gulbarga district by the AWCs is more or less satisfactory, except the three State sector taluks Chittapur, Jewargi and Yadgir taluks, where the number of AWCs is limited to 100 covering a population of one lakh, in each taluk. Whereas the population of Chittapur was 2,58,000 (table not presented) in 1981 itself; in Jewargi 1,53,000 and in Yadgir it was 2,23,000. By 1990, the population would be much higher, and therefore the coverage of ICDS in these three taluks in proportion to the actual population would be presently, extremely inadequate. In case of Raichur district, the population coverage was as per norm (of one anganwadi for every 1000 population) in Kushtagi, Lingsugur and Deodurg. In Yelaburga state project, the population covered by Anganwadis was one lakh against a total population of 139489 in the 1981 Census which would be much higher by now.*

Keeping in view the extreme backwardness in these four taluks, they would benefit greatly by converting to Central Projects on a priority basis, which would increase the number of Anganwadis and cover the eligible population.

*c. Coverage of targetted Beneficiaries*

The coverage of targetted beneficiaries for SNP in all the Projects which are operational in Gulbarga district is generally satisfactory (table not presented). A total of 72836 children of 0-6 age were covered in 1989-90 against a targetted number of 76877 beneficiaries in the Projects which are already operational (i.e. 94.7%). Thus the deficit in achievement of 25% evident at the State level was due to non-functioning of the two newly sanctioned Projects - Aland and Shahapur. The target fixed per Anganwadi for Gulbarga district as a whole works out to 74 in 1989-90 as against the ICDS norm of 80 per Anganwadi and the actual coverage was 70 children per Anganwadi. The target fixed in the State sector projects was slightly lower, coverage was satisfactory at 78 in Central Projects. In the group of pregnant and lactating mothers, the district target was 10166 and the coverage 9929. However, the targets of mother beneficiaries fixed per Anganwadi is 50% of that recommended under the ICDS (the scheme envisages that







under each Anganwadi, ten pregnant and ten lactating mothers would be provided supplementary nutrition).

In case of Raichur district the targetted number of child beneficiaries for supplementary nutrition was 45880 in 89-90 which worked out to an average of 71.3 per Anganwadi. This was considerably less than the ICDS norm of 80 target children per Anganwadi. In respect of the State Project Yelaburga, however, the target in 1989-90 was 79/Anganwadi (presumably due to higher utilization by beneficiaries), than the lower target of 68/Anganwadi fixed for Yelaburga during 1987-88 and 1988-89. It was also noted that in Yelaburga, the staff position of Anganwadi supervisors was the most satisfactory - 4 out of 5 sanctioned in position, which has possibly influenced ICDS implementation and beneficiary utilization.

The target of pregnant and lactating mothers in Raichur district also has been five each.

Beneficiaries covered in terms of targets, in Raichur has been satisfactory. In 1989-90, 91% of targetted child beneficiaries (in the operational projects), were covered (42,944 out of 45,880); among mothers also the coverage was satisfactory at 95% of targetted mothers being actually covered.

Overall, over the past few years the pattern of fixing targets and actual beneficiary coverage in Gulbarga district in the Central sector projects was consistent and satisfactory. In the State Projects, the targets were fixed far lower than the ICDS norm during 1987-88 and 88-89. Though improved during 1989-90, it was not as per norm. Actual coverage of targetted beneficiaries in the State Projects was satisfactory. In Raichur, lower targets are being fixed in Central Projects which needs to be revised upward for better coverage of eligible population under SNP.

*D. The information on coverage of SC/ST beneficiaries was available for 1985-86 for Gulbarga district. A total of 23718 SC/ST beneficiaries representing 32% of the total ICDS beneficiaries were covered for supplementary nutrition. This proportion is similar to the representation of the SC/ST population in the District which is about 30%. However, since most of the SC/ST population belong to the extremely backward and poor sections, and almost all would be eligible for ICDS, SC/STs are expected to be represented much more among the ICDS beneficiaries than their representation in the general population, if the objective of ICDS to reach out to the most underprivileged sections, is to be better achieved.*

This situation of inadequate service outreach to the SC/STs, was attributed to strong caste feelings in the District, as a result of which the SC/ST families were located at some distance from the main village and the young children are not able to walk/be escorted the







distance to the Anganwadi, which is usually located in the main village. The Anganwadi, tends to be located in the main village for two reasons. Firstly, any reasonable building in good condition is likely to be in the areas where the other castes live; secondly the Anganwadis are expected to be located nearest to the region of concentration of people so that there is better utilization of services and nutrition from the anganwadi. In fact, this was observed by the Study team in two villages namely Chandapur and Batgera-K villages of Sedam taluk. In case of Chandapur, the anganwadi had been shifted only a month before, from a building in the SC area to the main village, and this had greatly improved the attendance at the Anganwadi since the anganwadi was shifted close to the area of concentration of people. On the other hand, the Scheduled caste/scheduled tribe children who were now located far away, had largely dropped out from the Anganwadi. In case of Batgera-K the Anganwadi was located in the scheduled caste area and the remaining villagers do not make use of any of the anganwadi services since the worker belongs to the scheduled caste as well as the helper who cooks the food. The attendance in this anganwadi consisted purely of scheduled caste children, but in term of absolute number of children utilizing the services, it was low.

#### *E. Availability of buildings for Anganwadi*

Under the ICDS, the community is expected to provide a building. However, in Gulbarga district, out of 1366 anganwadis in 19909, 194 had been donated by the public, 222 were rented buildings, 232 were panchayat buildings, 26 were in anganwadi buildings constructed for the purpose, 214 were held in community halls, 192 were being held in a room provided by the local primary school. 143 were being held in temples, and 143 anganwadis were conducting the activities underneath the trees. This means that 31% of anganwadi buildings were provided by the local community which represented some degree of community participation in the scheme. In the case of rented buildings, the rent was paid by panchayats. Overall, only in 674 anganwadis or 49% of AWCs (rented buildings and other buildings exclusively used by the Anganwadi) the materials could be stored on the premises in Gulbarga district. In most other cases where the activities had to be carried out in multipurpose buildings or under the trees, materials have to be stored in the Anganwadi workers houses. In case of Raichur district also, out of a total of 592 functioning anganwadis, 89 were donated by the public, 103 were rented buildings, 84 were panchayat buildings, 23 were anganwadi buildings constructed for the purpose, 48 AWCs were conducting activities in community halls, 64 in a room provided by the primary school and 188 in temples and mosques. Thus in Raichur district also about 29% of buildings had been provided by the local community. Overall, considering the buildings under the custody of the AWW to store the materials, only in 50% of anganwadis of Raichur district the food material could be stored in the premises.







Therefore, it could be anticipated that there is scope for misuse of food items in almost 50% of anganwadis in both districts.

*F. Availability of Staff:*

50. The overall availability of staff in Gulbarga and Raichur districts is shown in Table 19:

i) In Gulbarga, two posts of Child Development Officers are vacant. As a result, CDPOs of neighbouring projects are in charge, in addition to their projects. 64 out of 87, almost 75% posts of supervisors are vacant. In case of Anganwadi workers, the situation is good. Almost all the sanctioned anganwadis have AWWs in position and also most of the AWWs are trained. It was reported that in general, in Gulbarga district, almost 80% of the anganwadi workers belonged to the same village. Considering the qualification of anganwadi workers in 1985-86, 473 out of 920 anganwadi workers (about 53%) were SSLC passed candidates and the remaining had passed the 7th class only. The anganwadi worker turnover was reported to be quite high, at almost 10%. This was mainly due to marriage of the girls.

ii) In Raichur district the post of Assistant Director was vacant and also post of one CDPO. Thus three CDPOs were sharing the responsibility of four projects and the functions of Assistant Director, which in this district with farflung areas is difficult to execute efficiently. The position with regard to supervisors was far better than Gulbarga district, 18 of sanctioned 30 in position but still far from desirable. The deficit of supervisors was most in Lingsugur Project where only three out of 10 sanctioned were in position. It was comparatively good in Yelaburga Project where 4 out of 5 Supervisors were in position. The staff position of Anganwadi workers and helpers was good. However, with regard to residence of AWW in the village of work, which is required under ICDS, the position was not so good. Only 277 or 47% of AWWs resided in the village of work; 100 lived within 5kms; 70 lived at a distance of 5-10 Kms; 46 at a distance of 10-20 kms and 99 lived more than 20 kms away. A worker living away from the village of work and particularly living very far, is not likely to be efficient or regular in her duties due to vagaries of local transport. Thus it could be surmised from the above figures in that the programme may be functioning at less than optimum efficiency in many parts of Raichur district. (This was one reason why targets have been fixed lower, so that if work is not going on satisfactorily, the misuse of food items at least, can be misused.)

iii. The educational qualification of AWWs in Raichur was however better than in Gulbarga district. In Raichur, 63% of AWWs (354 of 587) were qualified with SSLC or further and only 37% were non SSLC as compared with 47% non SSLC candidates in Gulbarga district.







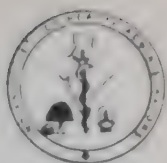
iv. However, to some extent, the quality of AWWs is expected to improve in the future. The turnover of the anganwadi workers due to marriage has been resulting in selection of new candidates, who now-a-days tended to have SSLC qualification, due to improvement in the educational status in the villages. In this connection, it was felt that there is a critical need for careful selection of AWWs and that is why the officers felt that newly started projects should have full complement of supervisory posts as well as full time CDPO, before the project starts, since the CDPOs and Supervisors are crucial to undertake a thorough survey and investigation of every village to identify the most suitable, better-qualified, preferably married lady of the village to be selected as an anganwadi worker. Otherwise, the selection of anganwadi workers has to be done based on patchy information given by vested interest groups from the villages, which sometimes results in recruiting ladies from neighbouring or distant villages who may be married or may not be married and settled, inspite of suitably educated and locally settled ladies being actually available in the villages. This was illustrated by the case of Chittapur.

Table-19  
Staff Position as on 12.11.1990  
in Gulbarga and Raichur Districts

S.No.	Designation	Gulbarga District		Raichur District	
		Sanctioned	In position	Sanctioned	In position
1.	Assistant Director				
	Gulbarga	1	1	1	-
2.	Women and Child Welfare Officer, Gulbarga	1	1	1	-
3.	Children's Development Project Officers (CDPO)	11	9	4	3
4.	ACDPOs	10	7	2	2
5.	Anganwadi Supervisors	87	23	30	18
6.	Anganwadi Workers	1517	1503	592	588
7.	Superintendent Grade II	2	2	1	-
8.	First Division Assistants	26	18	7	5
9.	Second Division Assistants	11	7	1	-
10.	Typists	2	2	1	-
11.	Peons	20	7	6	4
12.	Drivers	17	9	5	5
Total		1706	1589	651	625







#### 48. Major Constraints and Issues in the Two Districts

##### A. Constraints of Human Resources:

The major constraint for implementation of the ICDS programme and also other programmes was lack of adequately educated and skilled personnel. This constraint was being felt at all levels. Further, new projects were being sanctioned without posting the required staff to take over the work in these projects and existing staff in other projects were redistributed or requested to hold additional charge. The indiscriminate ban on recruitments by the Government, irrespective of the crucial need for field personnel has resulted in a situation where, since 1985-86 no recruitment of CDPOs and Supervisors has taken place, whereas three new projects were initiated in Gulbarga district alone and one in Raichur District. Unless the critical posts of CDPOs and Anganwadi Supervisor (for every 20 Anganwadis) were filled at the start of the project, much long term damage to the implementation and achievement of Programme objectives could be done. The case of Chittapur taluk was quoted, where the baseline survey could not be carried out properly owing to lack of staff. The sanctioned number of Anganwadis were located without adequate information as to the optimum place for best utilization by the community. As a result, in many parts of Chittapur, there are Anganwadis which are poorly or very little utilized because of distance of the Anganwadi from the main village, or long distance from the residential areas of the scheduled castes.

Even now, a similar situation is apprehended in Aland Taluk which was sanctioned in 1988-89 but soon to become operational. Out of a total of 13 supervisory posts required, only two are filled. Establishment of Anganwadis under these circumstances is likely to result in inappropriate location of Anganwadis. Also selection of workers based on patchy information could lead to inappropriate persons being selected as AWWs even though suitable qualified candidates may actually be available. In contrast, in Bidar district under the Bidar Integrated Rural Development Scheme, majority of the supervisors posts were kept occupied and this has resulted in very good performance by most taluks of the district. Particularly during the early phase of the Projects of Bidar district, full post occupancy of CDPOs and supervisors has resulted in highly efficient functioning of the ICDS Programme. (This situation is in fact reflected in the nutritional status figures reported from the projects of Bidar district to the State Nutrition Monitoring Cell of the Department of Health and Family Welfare.) Another case of good performance directly attributed to adequate number of supervisors was Sindgi taluk of Bijapur district, where the present CDPO of Sedam had served previously. When he joined as CDPO of Sindgi in 1987, 1087 children were reported to be suffering from severe malnutrition. By 1990, just before he left for his present posting, the number of severely malnourished had come down to 230. The critical factor in the success was supervisors -- 11 out of 11 sanctioned were in position.







b. Apart from adequacy of staff in the two districts, the education and skills level of staff was frequently inadequate for the nature of duties required to be performed in the ICDS programme. At the level of supervisors, graduate qualification is required if the person has to cope with the nature of work. However, in Gulbarga and Raichur districts, there are many supervisors promoted from Mukyasevikas and other posts, who are not graduates. The need for graduate qualification (which implies atleast certain minimum level of abilities and skills) is illustrated by Basavakalyan project of Bidar district where 7 of 10 supervisors are promotees from Balasevikas who are SSLC candidates. They are unable to supervise properly or guide the Anganwadi workers and as a result, Basavakalyan is generally acknowledged to be the poorest performing project in Bidar. In contrast, in Humnabad taluk of the same district Bidar, where the same (present) CDPO of Chittapur taluq had also served previously, all supervisors were in position and were graduates, as a result of which it was one of the best projects.

c. Among the Anganwadi Workers, only about 50% of the workers had passed their SSLC. Whereas in the districts which are advanced such as Uttara Kannada or Shimoga, the Anganwadi workers and supervisors are well qualified, many of them being graduates, which results in better performance of the worker and as well as better recording and reporting. In the case of Humnabad taluk of Bidar, a neighbouring district, the high qualification of the Anganwadi workers has resulted in highly efficient programme being in progress. In this taluk, out of 124 Anganwadi workers, 15 were graduates, 47 were PUC qualified with teachers training qualification 60 had passed the PUC and 2 were post graduates (M A Qualification) . Most of the rest were SSLC. Similar was the case quoted of Gadag taluk where even SSLC anganwadi workers were far more skilled and "educated" as compared with the SSLC qualified worker in Gulbarga district.

d. All the officers felt that keeping in view the low educational level of the Anganwadi workers and mostly inadequate number of supervisors, the ICDS programme could not be improved further unless the supervisory staff position was drastically improved. (There are few projects such as Chittapur where one Supervisor is in charge of 224 Anganwadis) On the whole in Gulbarga district, on the average, a supervisor was in charge of 60 anganwadis, a situation combined with many under-qualified supervisors, under-qualified anganwadi workers and low community awareness to demand the services. Thus the ICDS programme in Gulbarga district was functioning chiefly as a feeding programme. The supervisors during their rare and quick visits (due to very long distance, bad roads and infrequent bus services), can barely concentrate on supervising and checking the food items to check misuse of food items supplied under ICDS. In spite of these constraints, most of the officers concurred that about 30% of the anganwadis in the districts, which are located in accessible areas and well connected with the circle headquarters were functioning with optimum efficiency







even in terms of preschool education and nutrition education. Optimum frequency of supervision, in their opinion, was invariably followed by efficient functioning in terms of feeding programme, pre-school education, promotion of hygiene and cleanliness among children, and nutrition education.

B. The second major constraint identified was, extreme poverty and educational backwardness of the people. As a result, the community demand and participation which is required for maintaining the quality of services at village level, is not forthcoming.

C. The third major constraint identified was, extremely poor roads and far-flung villages, particularly in taluks such as Sedam and Chittapur. Most taluks have kuchha roads, where bus services were withdrawn for about six months of the year during rainy season. This was a serious constraint and as such, many such Anganwadis would be visited hardly once in six months or a year by the Anganwadi Supervisors. The situation was a little better in Raichur district with relatively better accessibility of the villages.

D. With regard to the administrative aspects, it was felt that since 1987-88, when the administrative authority for the Programme implementation was handed over to the Zilla Parishad, much problem was experienced particularly with regard to the timely release of funds. As a result, every year since 1987, the feeding programme has to be interrupted, sometimes for two or three months at the beginning of the financial year. Even the funds for routine local purchase of additional food items of 14 ps per beneficiary, and transportation charges are not released in time. Often the CSB has been stored in the Project Offices for months together without reaching the villages owing to this problem. It was felt that, since in any case the amount for ICDS projects is fixed according to the standard norms per beneficiary, and there is no question of any discretionary changes to be made, this procedure of routing routine matters related to programme implementation though Zilla Parihad should be eliminated.

Another constraint was the lack of anganwadi buildings in many villages. As a result, in these villages the anganwadi worker stored the food items in her house which resulted in misuse of items for personal use or even sale in some cases.

To summarize, the major problems identified in both districts of Gulbarga and Raichur were those of , highly unsatisfactory staff position of supervisory staff; low education level of the anganwadi workers and to some extent the supervisors; poor road communication; extremely backward and poor village communities which resulted in low demand for services; procedural constraints on account of routing routine financial matters though Zilla Parishads and lack of anganwadi buildings to ensure proper utilization of the resources.







#### 49. Major Issues of Concern with the Five Selected Projects

##### i. General:

The data on these taluks showed that, Sedam taluk in Gulbarga and Deodurg taluk in Raichur district were the most recently started (among the established) Projects - Sedam Project sanctioned in 1986-87 and Deodurg sanctioned in 1987-88. However, implementation of both projects had been delayed and thus each could serve as a control of taluk in each of the districts. Data at State level on, nutritional status, regularity of reporting, possible reliability of figures and other indicators, suggested that among the Projects of Gulbarga District, Afzalpur would be a well progressing project; and Chittapur among the most poorly progressing taluks. In Raichur, Lingsugur appeared to be an average performing project and not much data was available on Deodurg, a recently started project. Information, discussion and observations at the field level confirmed the inferences made based on State level data. The officers of Women and Child Welfare Department attributed the relatively better performance of Afzalpur taluk compared to Chittapur and Sedam, to the following factors: Afzalpur taluk generally used to have a more comfortable supervisory staff position as also availability of quarters/local buildings for supervisors to stay in the respective circle (PHC) headquarters, which facilitated regular visits and supervision. Roads were relatively better and most villages were accessible. Also, relatively, Afzalpur taluk was better off with lift irrigation and few cash crops such as bananas. People in general were better educated or atleast more aware than the other two projects visited.

ii) Chittapur is a State Sector Project with consistently low supervisory staff position over the years. Being a State Sector Projects, the allocations of funds was not as per the Central ICDS Project norms. Funds for Mahila Mandals are not allocated due to paucity of funds, unlike the Central Projects where funds are regularly earmarked for the purpose. Similarly pre-school kits, health kits, are not supplied as in the Central Sector projects. Very low level of education and awareness is found in the population of Chittapur. As a result of this factor, together with lack of adequate supervision and poor education qualifications of the Anganwadi worker, the Anganwadi worker has not been able to become a resource person in the village, to increase general awareness. She herself is less qualified and with less concepts of human relations skills to work with the community. In Chittapur Project, which was taken up very early in the history of ICDS in the State, i.e 1977-78, baseline information, based on which the Project implementation was done, was inadequate. Thus of the 100 villages which have Anganwadis (of total 147 villages), the location of anganwadis in atleast 25% of villages is not appropriate and it is difficult to shift now, owing to local pressures, nor can new ones be opened in the thicker populated areas because of the ceiling of 100







Anganwadis for State projects. As a result, the utilization of services had always been erratic in Chittapur. Consequently the targetted figure of 100/Anganwadi was found to be high compared with the actual utilization by beneficiaries, a situation which tended to result in more misuse of food articles. To minimize wastages of funds, in 1987 the average targetted number of child beneficiaries per anganwadi was reduced from 80 to 68 (although this target is adjustable between thickly populated areas with well functioning anganwadis and remotely located anganwadis). Also, for the same reasons of inadequate field information for the Project management in the early years, it was reported that 82 of 100 Anganwadi workers are residing away from the village. The problems of project implementation which arose due to inadequate staffing in the early years could not yet be corrected because the same problem continues even now.

iii) In Sedam taluk, the outstanding feature was lack of supervisory staff (one of five sanctioned, in position) combined with extremely poor, clay-topped roads. For 34 of 96 revenue villages, the roads are inaccessible for months of the year and State bus services are closed down totally from June - November, making it impossible to supervise them atleast during half the year. In Sedam, a major problem also, was high degree of illiteracy and poor human relations skills of the Anganwadi workers owing to low educational level. The fourth major constraint in Sedam taluk was language. About 25% of anganwadi workers near the Andhra border understand only Telugu, and the supervisors find difficulty to communicate. Another 15-20% understand only Marathi and thus supervisors find difficulty to communicate.

A distinguishing feature of Sedam taluk was that 37 of 129 anganwadi workers belonged to scheduled caste and these 37 anganwadis were mostly located in scheduled caste areas.

Due to very poor roads, it has been difficult to get contractors for transport of food materials to the villages in both Chittapur and Sedam. In Chittapur, month to month adhoc arrangements for transporting food materials are being made by the CDPO and as a result, there is frequently delay in food reaching or in some areas food is not reaching during certain months.

iv) In the case of Deodurg taluk of Raichur district, the outstanding problem was that of poor roads and difficulty to reach the villages due to lack of bus services. Deodurg was reported to be one of the most backward in Raichur district.

v) In Linsugar, the major problem experienced was lack of supervisors, only 4 of 10 sanctioned supervisors were in position. This problem was compounded by a situation where, nearly 60% of anganwadi workers lived away from the village of work. Thus it was difficult to ensure a certain standard of implementation of the ICDS.







Data regarding population coverage, project wise position of key staff and visits of medical officers to anganwadis was in keeping with the general district picture and is presented in Appendix 2,3 and 4.

#### 50. Assessment of ICDS Programme at the Anganwadi Level

a. The functioning of the ICDS programme at the grassroot level, namely the anganwadis, was assessed through visits to ten anganwadis, one well-supervised and one infrequently supervised anganwadi in each of the five projects (The list of anganwadis visited is indicated in Chapter III). The observations of the Study team are summarized in the following paragraphs:

b. Feeding programme was more or less satisfactory in all AWCs but much more so in the frequently supervised anganwadis. Growth monitoring of children who were not enrolled for SNP needed more emphasis. Pre-school education and promotion of cleanliness and hygiene of children were two striking characteristics of the more frequently supervised AWCs (However the primary schools in most of these villages did not report increasing school attendance/enrollment over the years.) This was reported to be due to the need for children of 6-8-10 years to attend to minor farming activities or to younger siblings when parents are away at work.

c. The well supervised AWCs also showed better performance in terms of record maintenance, home visiting and attempts to convince the population of need for immunization which resulted in better acceptance. These AWCs also participated to some extent in Vitamin A prophylaxis and nutritional anemia prophylaxis, though these aspects need to be streamlined further. Overall, the role of supervision in maintenance of activities at high levels was amply illustrated in this study.

d. Functional aspects of the anganwadis which needed greater emphasis were as follows :

i) Care of under-six children who are not on the rolls for SNP

ii) Emphasis on importance of Vitamin A and anemia prophylaxis so that the AWCs seek out the services of ANMs for these programmes as they now do for immunization.

iii) Emphasis on health education regarding appropriate child nutritional practices in the area, hygiene, sanitation, use of safe drinking water and child care.

The detailed observations are on Anganwadi functioning given in Appendix - 6.







ISHA

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51. The observations on nutritional status of under six children in the selected projects were as follows:

A. *General:*

The nutritional status of children in Gulbarga district as a whole has been found to be relatively poor compared with the rest of the State in nutritional surveys, and in Raichur it has been found to be generally average as indicated in Chapter II. The reasons for high prevalence of child malnutrition in these districts are:

a) High fertility rate in these districts due to poverty and relatively large proportion of population belonging to Muslim and Scheduled Caste and Tribes, groups which are generally associated with higher fertility. In Gulbarga district, almost 60% are accounted for by these groups.

b) Very low literacy rate of females (less than 10%) which is associated with low age at marriage, high fertility (with less spacing resulting in low birth weight babies) and poor awareness of need for child care and nutrition, - for example the value of green leafy vegetable in the diet is not at all recognized in the districts particularly Gulbarga. Even farmers who have adequate land, who grow cash crops, rarely grow and consume adequate vegetables.

c) The feudal culture promoted during the Nizam's period for centuries, tended to promote a culture of submissiveness and passive acceptance of poverty, and did not encourage independence and entrepreneurial abilities.

B. *Assessment of Nutritional Status in the Study.*

With the objective of studying the impact of ICDS in these districts, the children attending the selected anganwadis were subjected to a clinical assessment of nutritional status. The assessment included, weight of the child (for age), general examination for hair signs (easy pluckability, discoloration and sparseness), eye signs (for conjunctival xerosis, Bitots spots and Keratomalacia), skin signs (crazy pavement dermatosis, pellagra and phynoderma) and subcutaneous oedema. The findings are presented in the following paragraphs:







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a. *Prevalence of normals, moderate and severe malnutrition*

Table 20 presents the proportion of children under six years of age who were classified as normal, Grade I, Grade II, III and IV respectively based on the Indian Academy of Pediatrics classification. The prevalence of these categories was found to be similar in both districts. Of the total 217 children assessed, 25.8% were classified as normal, 24.4% Grade I (mild malnutrition), 34.6% as Grade II (moderate malnutrition) and 15.2% as severe (Grade III and IV). Prevalence of Vitamin A deficiency was negligible with 2.3% showing eye signs. Prevalence of hair signs was high at 9.2% and this was in line with the high prevalence of severe malnutrition. No case of frank Kwashiorkor was seen.

b. *comparison of nutritional status of children in the most recently started Projects and the older projects*

The projects studied were classified into most recently started projects of the districts (Sedam sanctioned in 1986-87 Gulbarga district and Deodurg sanctioned in 1987-88 of Raichur District) and the older Projects. All the older projects were in operation for more than six years. Afzalpur and Chittapur Projects were eight and twelve years old respectively and Lingsugur was six years old. Sedam and Deodurg were neighbouring projects in the same districts with comparable socioeconomic conditions, and the field implementation of both ICDS projects had been delayed so that these two could be designated as recently started projects or controls. A comparison of the nutritional status of children in these two sets of Projects is presented in Table -21.

The proportion of normals, and normals + grade I, were 31% and 56.5% respectively, in the earlier started projects and corresponding proportions in the recently started projects were 19.6% and 43.1% respectively. The differences between the proportions of normals as well as the proportions of normals + grade I put together were both statistically significant.

The proportion of severe malnutrition in the earlier started Projects was similar to that in the recently started Projects. Overall, the prevalence of normals and mild undernutrition was higher in the older projects, and prevalence of moderate malnutrition was higher in the recently started projects suggesting that the ICDS programme had a favourable impact on the under six nutritional status (The prevalence of clinically evident Vitamin A deficiency among the children was too small to comment on the differences between the recently started and old projects).





Table - 20

Nutritional Status of Children Attending Anganwadis in Selected Villages of Gulbarga and Raichur Districts and Clinical Findings of Their Health

Village/ District	Total No. of Child- ren asse- ssed	Nutritional Status of Children (weight for age ) Number%					Clinical Observations: No.of Childrens with									
		Normal	Gr.I	Gr.II	Gr.III	Gr.IV	Bitots spots + Conxero- xis	Hair signs	Pal- lor	Chel- osis	Pol- io	Diar- hoea dehyd- ration cy	Vit A defi- cien- cies	Conju- ctivi- ties	frontal bossing	others
Gulbarga Dist (5 villages total	110 (100.0)	30 27.3%	24 21.8%	39 35.5%	14 12.7%	3 2.7%	2	11 10%	9 8.2%	-	-	11	1	1	6	8
Raichur Dist. (4 villages total)	107 (100.0)	26 24.3%	29 27.1%	36 33.7%	12 11.2%	4 3.7%	3	9 8.4%	13 12.1%	3	2	2	1	3	6	15
Total (Gulbarga & Raichur districts 9 villages)	217	56 25.8%	53 24.4%	75 34.6%	26 12.0%	7 3.2%	5	20 9.2%	22 10.1%	3 1.4%	2	3 1.4%	2	3 1.4%	12 5.5%	23 10.6%

Note: Percentages wherever are expressed to total number of children assessed.







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Table-21  
Nutritional Status of Children attending Anganwadis in Recently  
Started Projects and Six Plus Year Old Projects  
(Weight for age)

	Total No. of Children assessed	Gulbarga and Raichur Districts				Bitot's spots and Conjunct- ional Xerosis	Hair Signs
		Nutritional Status					
		Normal	Gr.I	Gr.II	Gr.III & IV		
Earlier started projects (Afzalpur Chittapur and Lingsuguar)	115	36 (31%)	29 (25.5%)	31 (27%)	19 (16.52%)	1	10
Recently started projects (Sedam and Deodurg )	102	20 (19.6%)	24 (23.5%)	44 (43%)	14 (13.7%)	4	10





*c. Comparison of nutritional status of children in the frequently supervised group of Anganwadis and the infrequently supervised group:*

It was hypothesized that possibly the ICDS programme as a whole may be more satisfactory and therefore making a better impact on nutritional status of children in the frequently supervised group of anganwadis as compared with the infrequently supervised group. Nutritional status of children attending these two groups of Anganwadis was compared and is presented in Table 22.

There was no difference in nutritional status by weight of children attending the two groups of Anganwadis.

Hair signs of malnutrition are particularly indicative of severe protein malnutrition. The supplementary food provided under ICDS provides 8-10 grams of good quality protein. Therefore one of the indicators studied was prevalence of hair signs.

There was a significant difference in prevalence of hair signs among children attending the frequently supervised anganwadis (4.7% prevalence) compared with those attending the infrequently supervised anganwadis (13.5%). This suggests two to three reasons. Firstly, it could be reasonably expected that the feeding programme would be more regular and satisfactory in the oft supervised ananwadis and therefore better delivery of protein rich supplementary food in these as compared with the anganwadi seldom or not at all supervised. Secondly, the anganwadi workers in the former group may be better oriented to watch for hair signs and take extra care, as compared with the latter group. Better cleanliness and hygiene in the former group could be associated with less parasitic infestations and lesser incidence of diarrhoea, which may be protecting against severe problem of malnutrition.

An attempt was made to study the differences in nutritional status of male and female children which is shown in Table 23. There was no difference in nutritional status between the two groups in term of either normals or Grade I - IV.

## 52. Summary of findings of nutritional status

To summarize the findings of nutritional status, the ICDS programme had made significant impact on the nutritional status of children in the established projects. There was also a significant difference in terms of protein malnutrition between children attending the frequently supervised anganwadis as compared with the infrequently supervised in these two districts. However, this aspect needs a large scale study to conclusively establish the role of supervision frequency on the impact of ICDS on nutritional status.





Table - 22

Nutritional Status of Children in Frequently Supervised and Infrequently Supervised Groups of Anganwadis in the two districts

Frequency of Supervision	Total No. of Children assessed	Nutritional Status of Children (weight for age )		Clinical Observations: No. of Childrens with											
		Normal	Gr. I	Gr. II	Gr. III	Gr. IV	Hair signs	Bitots spots + xerosis	Pal-losis	Chei- Polio dehy- dration	Vit A deficiency	Conju- nctiv- ities	frontal	others	
1. More frequently supervised															
Supervised	106	26	25	40	11	4	5	2	11	-	3	1	7	13	
AWCs (Gul. & Rai Dists. (4 AWCs)	(100.0)	24.5%	23.6%	37.7%	10.4%	3.8%	4.7%	1.8%	10.4%	-	2.8%	0.9%	6.6%	12.3%	
2. In-frequently supervised															
Supervised	111	30	28	35	15	3	15	3	11	3	2	1	3	10	
AWCs Gul. & Rai. Dists (5 AWCs)	(100.0)	27.0%	25.2%	31.6%	13.5%	2.7%	13.5%	2.7%	9.9%	2.7%	1.8%	0.9%	2.7%	9.0%	
3. All AWCs															
Supervised	217	56	53	75	26	7	20	5	22	3	2	2	12	23	
AWCs (Gul. & Rai. Dists. (5 AWCs)	(100.0)	25.8%	24.4%	34.6%	12.0%	3.2%	10.1%	2.3%	9.2%	1.4%	0.9%	0.9%	5.5%	10.6%	

Note: Percentages wherever are expressed shows total number of children assessed





Nutritional status (Weight for age) of Anganwadi Children in Selected Villages of Gulbarga and Raichur District  
 Table - 23  
 Classified by Sex

District	Total No. of Children assessed	Male Children (Number)					Female Children (Number)						
		Total	Normal	Gr. I	Gr. II	Gr. III	Gr. IV	Total	Normal	Gr. I	Gr. II	Gr. III	Gr. IV
Gulbarga District (5 villages)	110	59 (100.0)	16 (27.1)	11 (18.6)	26 (44.1)	5 (8.5)	1 (1.7)	51 (100.0)	15 (29.4)	12 (23.5)	13 (25.5)	9 (17.7)	2 (3.9)
Raichur District 4 villages	107	54 (100.0)	14 (25.9)	15 (27.8)	18 (33.4)	6 (11.1)	1 (1.8)	53 (100.0)	12 (22.6)	14 (26.4)	16 (34.0)	6 (11.3)	3 (5.7)
Total	217	113 (100.0)	30 (26.5)	26 (23.0)	44 (38.9)	11 (9.8)	2 (1.8)	104 (100.0)	27 (26.0)	26 (25.0)	31 (29.8)	15 (14.4)	5 (4.8)

Note: Figures and brackets indicate the percentage to total male/female children.







53. Summary of Observations and Issues in the ICDS Programme in the State and Two Study Districts

i) In summary, all indications at the State level showed the high commitment of the State Government to the philosophy and objectives of the ICDS Programme - namely, to improve the nutritional status and child development, especially in the most needy areas. Indicators of coverage of backward areas, coverage of poorest taluks, adequate budgetary provisions both for supplementary nutrition as well as administration, reflected this commitment. However innovative strategies were needed to increase the coverage of two vulnerable groups - namely 0-3 aged children and, pregnant and lactating mothers as also the Scheduled Caste and Scheduled Tribe Population.

ii) To improve the coverage State sector projects particularly in droughtprone areas need to be converted to Central Sector Projects on a priority basis. To improve the qualitative aspects of coverage in the State, the most backward taluks into the State which are not yet covered by ICDS, need to be identified and covered, on a priority basis, before taking up any more advanced taluks.

iii) The State level information on nutritional status of children in the ICDS Projects suggests that a declining trend of malnutrition was seen in many projects during 1986-90 and remained static in many others. Decline was more obvious in recently started projects of Mysore division, reporting was more uniform and many taluks reported low prevalence of malnutrition from this division. By these indicators, Gulbarga division was quite poor in terms of present nutritional status and particularly poor was the Gulbarga District.

Nutritional status data together with administrative details of budget utilization, staff position and beneficiary coverage suggested that the present status of ICDS Programme in Gulbarga district as well as to some extent in Raichur district, is below the State average.

iv) A major constraint in the ICDS Programme chiefly related to inadequacy of personnel to handle the programme, particularly the key field officers and staff, and more particularly in newly started projects. This is a pressing problem, since all indications in Gulbarga and Raichur districts showed that, with inadequacy of these categories of staff, the expenditure being incurred on SNP which is substantial, would also be considerably less efficiently utilized and less effective in achieving Programme objectives.

v) Newly sanctioned projects need to have the full complement of CDPOs and supervisors atleast for the first two years, particularly in droughtprone and backward areas, so that baseline survey, proper location of anganwadis, recruitment of best available anganwadi workers residing in the same village, are accomplished. Failure to do







this in initial stage would result in many permanent handicaps for the project, as evidenced by Chittapur.

vi) Regarding intersectoral coordination, the success of immunization programme, particularly in the ICDS taluks in the UIP district showed the Health and Women and Children's welfare Departmental functionalities. However, not much assistance of the ICDS infrastructure was being availed for other health programmes such as Vitamin A and anemia prophylaxis. Since these National Programmes are also crucial for child development, a concrete strategy could ensure a continuing liaison between the ICDS field functionaries and health functionaries for these programmes.

vii) A third area with great potential is community participation. Community participation is crucial for long term success of the Programme, and the ICDS philosophy all along, has been stressing on this aspect. Indications are that, apart from some contribution by the Mandal Panchayat for fuel, and in some cases provision of Panchayat buildings, community participation is low, particularly in these two districts.

viii) A concrete strategy would be required to ensure community participation in the ICDS programme. Participation is needed in several forms-creches to take care of 1-3 years age group of children run by local persons, generation of public opinion on favour of family planning for better mother and child health, mobilization of local resources for nutrition component. These are long term community measures which need to be facilitated by the village AWWs. Apart from these long term forms of community participation, much potential exists to mobilize the community in a short term. The potential role of the village and community in contributing to improvement of its own children could be as follows:

a. Contributing vegetables and other items to add to the nutritive value of food for the children (The study team found that many nutritious items such as onion tops and edible green leaves of common crops (especially oil seeds and pulses) were being wasted by the villagers, while on the other hand, the AWWs complained of poor quality of supplementary food due to inadequate supply of vegetables and condiments)

b. Families or the community could grow drought -resistant trees of high nutritive value particularly for the children - drumstick trees and papayas. The kitchen garden concept, if widely practiced would do away with the problem of Vitamin A deficiency and remove the community dependence on the Vitamin A Programme for prevention of eye complications in young children. AWWs living in the villages could play a crucial role in the endeavour of popularizing kitchen gardens.







ix) If the above strategies are to be implemented effectively at the field level, it requires conviction and commitment to the community participation approach at all levels. This approach would require action programmes to train and orient staff at all levels on how to draw the participation of the community. It also requires intensive coordination with the Forestry Department and Agriculture Department and intensive efforts by all Project staff; but the rewards are rich and often far beyond what the original Programme or leaders envisaged. (The ISHA study of nineteen innovative Projects in health, development and family welfare in rural, tribal, urban and organized sector contexts by voluntary and Government agencies, bears out this point.\*

x. The system of having honorary anganwadi workers and helpers at the village level appears to be one of the major factors in the success of ICDS Programme. The limited observations of the study team in Gulbarga and Raichur showed quite high accountability being established by the AWW to the community. Since she was not a government servant, the community appeared to take greater interest in ensuring proper delivery of services. (This perception of "proper" services, of course depended upon the level of development of the village community). Major conflict between AWWs and the community was not observed in any of the villages, and the system seemed to be evolving towards better delivery of services. However, this process is slow and needs greater promotion of community awareness through better AWW performance in respect of community contacts which can be ensured by optimum supervisory inputs from the ICDS Supervisors.

xi. To summarize the present status of ICDS programme specifically in the two study Districts, admirable success was being achieved in keeping up the supplementary nutrition component, in the face of grave constraints. This was reflected in the beneficiary appreciation of the ICDS Programme (both supplementary nutrition and pre-school education), as well as favourable impact of the ICDS Programme on the nutritional status of children. (In the old Projects (6+ years of Project age) the child nutritional status was significantly better as compared with the recently started (control) projects). However, effective nutrition education and health education on community practices which closely impact child health, was conspicuously lacking in all villages but one. Also, in keeping with the above findings, emphasis on Vitamin A administration and anemia prophylaxis by ICDS functionaries was quite inadequate. Another aspect which needed attention was that in most of the villages, children not covered for SNP were not being monitored for growth, which is contrary to the ICDS philosophy.

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\* Community Participation in Health and Family Welfare - Innovative Indian Experiences, Indian Society of Health Administrators, Bangalore







A major finding of the study team was that, supervision was indeed a critical factor in qualitative aspects of implementation of ICDS programme at the village level, and also to some extent, in achieving better nutritional status. How far some of these factors are operation in the other districts of the State, could be assessed by a similar study in other districts.

xii. The critical programme constraints in these districts were (a) lack of key staff (b) poor coverage in State sector projects which were in operation in the most backward taluks - Chittapur, Jewargi and Yadgir. c) Low educational status and skills of the staff - poorly qualified AWWs needed greater supervision, as well as, inadequately qualified supervisors needed more time to do the same work (d) Long distances, very poor road communication and sparse population distribution (e) Lack of anganwadi buildings which hampered effective implementation at field level.

### IMMUNIZATION PROGRAMME

The present status of the immunization programme is reviewed in terms of the district-wise performance since 1985-86. The information on impact of UIP in the districts is also presented, keeping in view that the introduction of UIP in most districts, has proved to be a major landmark in the performance of the immunization programme. In Gulbarga and Raichur districts, the findings of the study on immunization coverage among beneficiary families interviewed, is also presented.

#### I. Status of Implementation

54. Table 24 shows the progress of introduction of Universal Immunization Programme in the State. By 1989-90, all districts in Karnataka, have been covered under UIP. It can be observed that Gulbarga district was brought under UIP in 1986-87 and Raichur during 87-88.







Table - 24  
Progress of UIP in the Districts of Karnataka State

1985 - 86	1986-87	1987-88	1988-89	1989-90
Kolar	Belgaum	Dharwad	Bellary	Bangalore (Urban)
Hassan	Bijapur	Raichur	Bidar	Bangalore (Rural)
	Gulbarga	Mandya	Shimoga	Mysore
		Tumkur	Chitradurga	Kodagu
		Uttara Kannada		
		Dakshina kannada		
		Chikmagalur		

Only 19 District Immunization units have been sanctioned. One Unit sanctioned for Bangalore is attached to the office of the District Health and Family Welfare Office, Bangalore (Urban) and looks after the Immunization activities in Bangalore Urban and Bangalore Rural Districts.

55. Table - 25, 26, and 27 show the performance of immunization under BCG, DPT and tetanus toxoid for pregnant mothers from 1985-86 upto 88-89 districtwise. The district reports of performance show high coverage for all the vaccines particularly during 87-88, 88-89.

56. A comparison was drawn between the immunization performance in the ICDS taluks as compared with the district as a whole and the data is shown in Tables 28-A and B. Overall, no difference was observed between the ICDS taluks and district as a whole, except in, Bijapur district from 1986-87 onwards, Kolar district from 1986-87 onwards, Raichur district from 86-87, Dharwad during 1988-89, Mandya during 88-89, Shimoga during 88-89 Tumkur 88 -89, U. Kannada 88-89. When increased coverage under ICDS taluks was reported for DPT. Incidentally, all these districts except Raichur had been brought under UIP one year prior to the years in which they started showing increased coverage in ICDS taluks over non-ICDS taluks. This suggests that introduction of UIP had a favourable effect on collaboration of ICDS staff to increase immunization performance.

## II. Impact of UIP

57. The impact of Universal Immunization Programme is being systematically monitored by UIP vaccination coverage surveys prior to and after introduction of UIP. This is done to correctly estimate the eligible population actually covered. The Vaccination Surveys have







observed marked differences in target achievement as reported and actual vaccination Coverage as found by survey. Table 29 shows the vaccination coverage found in UIP evaluation surveys vis-a-vis performances reported by the districts. Table 29 also shows that implementation of UIP resulted in substantially improved coverages for DPT third dose, Oral Polio Vaccination, BCG, measles, and tetanus toxoid for pregnant women as detected by the UIP surveys. The improvement was marked in the case of Hassan, Kolar, Mandya, Tumkur, Belgaum and Chickmagalur districts. Gulbarga district failed to achieve substantial improvement in coverage of children and mother inspite of UIP. UIP was implemented in Gulbarga in 1986-87 and by 1988, the coverage remained at 48% for DPT as it was in 1986-87, 29% for Measles, and 40% for tetanus toxoid for pregnant mothers. In 1989, the coverage for all vaccines remained almost same except tetanus toxoid for pregnant mothers which had improved to 60%. This is in contrast to all other districts which achieved 75% or more coverage within one to two years of implementation of UIP. However the situation was expected to have improved in 1990-91 since a massive effort had been launched. The above findings of vaccination coverage in the respective districts were generally in live birth with the incidence of vaccine preventable diseases in these districts (Ref. Chapter. II).

58. The major constraint for achievement of coverage in Gulbarga district was identified to be lack of adequate PHC medical officers, health assistants and health workers (female). It was expected that, with the recent improvement in health manpower position owing to training of Health Workers at the HFWTC Gulbarga, the situation would improve, and Gulbarga district would achieve similar coverage as other districts.

59. In November 1990, in Gulbarga district of the 550 posts of health workers (females) 150 were vacant, and of the 500 male health workers posts, 150 were vacant; 40% of posts of health assistants (females) are vacant. Combined with poor roads and pre-occupation with clinical responsibilities of existing medical officers, it had not been possible to execute the UIP satisfactorily in previous years. In the current year a massive effort was being made to achieve full coverage.







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Table - 25  
Districtwise Performance Under Immunization Programme in Karnataka - BCG

District	1985-86		1986-87		1987-88		1988-89	
	Ach.%	Target No.	Ach.%	Target No.	Ach. %	Target No.	Ach.%	Target No
1. Gulbarga	78.9	54,660	107.7	54500	86.6	55000	92.5	61000
2. Raichur	63.0	56640	94.0	42000	117.5	48000	103.2	54000
3. Bangalore (U)	74.5	85140	96.8	68500	68.4	83000	82.9	83000
4. Bangalore (R)	14.9	45468	98.7	47300	110.3	40000	92.8	40000
5. Belgaum	75.4	78936	81.5	75800	91.5	79000	97.0	9000
6. Bellary	83.9	38748	100.3	35000	109.7	7000	86.2	46000
7. Bidar	83.9	26364	96.5	26200	96.7	6000	98.7	29000
8. Bijapur	64.6	23456	106.7	62000	74.4	64000	87.3	71000
9. Chickmagalur	59.4	27660	97.3	21300	118.3	25000	87.0	27000
10. Chitradurga	47.9	45624	70.7	42100	84.9	40000	79.4	54000
11. Dakshina Kannada	71.8	62796	80.1	55500	129.4	63000	86.6	71000
12. Dharwad	50.0	78060	75.6	68800	97.1	76000	88.6	89000
13. Hassan	125.9	39672	98.5	35600	118.7	37000	107.9	41000
14. Kodagu	94.8	14628	115.9	11500	121.7	12000	108.6	12000
15. Kolar	118.0	50040	71.6	50000	110.2	51000	92.9	57000
16. Mandya	113.4	36840	78.9	33300	115.2	37000	99.6	42000
17. Mysore	61.8	68472	56.2	60700	113.4	56000	133.1	57000
18. Shimoga	56.8	46344	89.7	38700	102.5	37000	89.0	50000
19. Tumkur	72.7	52032	82.9	46200	101.6	53000	92.7	59000
20. Uttara Kannada	87.0	28428	114.1	25000	61.5	29000	85.8	32000
STATE	72.3	1000000	88.1	900000	98.6	950000	93.6	1064000







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Table - 26

Districtwise Performance Under Immunization Programme in Karnataka - DPT

District	1985-86		1986-87		1987-88		1988-89	
	Ach. %	Target No.	Ach. %	Target No.	Ach. %	Target No.	Ach. %	Target No.
1. Gulbarga	111.5	47200	114.3	54500	77.3	55000	92.4	61000
2. Raichur	121.2	38000	83.9	42000	101.4	48000	89.7	54000
3. Bangalore (U)	112.2	71000	126.5	68500	114.7	83000	102.1	83000
4. Bangalore (R)	101.1	49300	84.3	47300	79.5	40000	81.6	40000
5. Belgaum	99.2	72800	69.4	75800	70.1	79000	61.0	89000
6. Bellary	103.8	35000	79.7	35000	89.9	37000	80.0	46000
7. Bidar	83.4	30000	92.1	26200	11.6	26000	103.0	29000
8. Bijapur	92.9	58200	77.6	62000	57.6	64000	70.6	71000
9. Chickmagalur	123.1	22200	89.4	21300	86.8	25000	75.9	27000
10. Chitradurga	67.8	43200	71.1	42100	78.9	40000	73.9	54000
11. D. Kannada	104.9	57600	80.8	55000	107.1	63000	76.3	71000
12. Dharwad	91.2	71400	61.7	68800	82.6	76000	71.5	89000
13. Hassan	135.3	33700	90.6	35600	109.3	37000	96.0	41000
14. Kodagu	132.4	11200	107.1	11500	99.6	12000	104.9	12000
15. Kolar	114.2	47400	58.4	50000	86.7	51000	81.9	57000
16. Mandya	110.0	34500	91.6	33300	87.5	37000	87.0	42000
17. Mysore	104.2	62900	84.9	60700	111.7	56000	113.6	57000
18. Shimoga	100.3	40300	91.8	38700	93.5	37000	72.5	60000
19. Tumkur	107.9	48100	87.7	46200	105.4	53000	105.4	59000
20. U. Kannada	121.9	26000	66.5	25000	61.7	29000	69.1	32000
STATE	104.5	900000	84.6	900000	90.1	950000	83.0	96400







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Table - 27

Districtwise Performance Under Immunization Programme in Karnataka - TT (Expectant Mothers)

District	1985-86		1986-87		1987-88		1988-89	
	Ach.%	Target No.	Ach.%	Target No.	Ach.%	Target No.	Ach. %	Target No
1. Gulbarga	66.5	46000	76.0	54500	86.6	56600	75.5	66000
2. Raichur	87.9	39250	100.8	42000	98.1	50200	88.1	58000
3. Bangalore (U)	106.8	64400	98.6	68500	95.9	87400	98.8	87400
4. Bangalore (R)	72.7	44570	87.3	47300	88.4	41600	93.8	41600
5. Belgaum	74.4	65600	64.2	75800	77.7	82900	92.0	95000
6. Bellary	107.4	32760	91.9	35000	110.0	39600	78.9	49000
7. Bidar	76.3	22780	97.4	26200	105.6	27200	87.3	31000
8. Bijapur	74.7	52850	66.8	62000	64.1	67300	70.4	76000
9. Chickmaglur	116.7	20060	110.2	21300	88.5	26000	84.2	29000
10. Chitradurga	91.3	38940	96.2	42100	110.9	41600	83.9	58000
11. D. Kannada	89.1	52300	79.0	55500	99.3	65900	80.6	76000
12. Dharwad	100.4	64790	91.6	68800	92.5	81900	85.7	95000
13. Hassan	97.8	30450	97.1	35600	121.7	38800	101.9	43000
14. Kodagu	118.7	10160	120.8	11500	118.8	12600	110.0	13000
15. Kolar	71.8	43000	62.9	50000	82.1	53200	77.0	61000
16. Mandya	122.0	31200	105.0	33300	108.7	38200	82.8	45000
17. Mysore	94.6	57300	96.8	60700	135.0	58400	109.7	60000
18. Shimoga	86.1	36450	93.8	38700	106.2	39000	71.6	54000
19. Tumkur	110.0	43520	95.6	46200	77.3	55800	86.2	63000
20. U.Kannada	86.0	23580	72.0	25000	63.5	35800	66.4	35000
STATE	92.5	820000	87.0	900000	94.3	1000000	85.6	1136000





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Table - 28 A

Performance Under DPT Immunization Programme in Karnataka -- ICDS and Non-ICDS Taluks  
(% Targetted)

Sl.No District	1985-86		1986-87		1987-88		1988-89	
	Dist.Ach.	Tqs.Ach.	Dist.Ach.	Tqs.Ach.	Dist.Ach.	Tqs.Ach.	Dist.Ach.	Tqs.Ach.
1. Gulbarga	111.5	53.4	114.3	109.5	77.3	-	92.4	71.3
2. Raichur	121.2	63.2	83.9	120.6	101.4	85.0	89.7	91.9
3. Bangalore (U)	112.2	67.20	126.5	91.0	114.7	-	102.1	94.3
4. Bangalore (R)	101.1	47.0	84.3	64.0	79.5	-	81.6	64.9
5. Belgaum	99.2	69.0	69.4	78.0	70.1	-	61.0	74.3
6. Bellary	103.8	71.4	79.7	97.3	89.9	77.6	80.8	76.4
7. Bidar	83.4	52.5	92.1	84.5	111.6	75.6	103.0	88.0
8. Bijapur	92.9	37.0	77.6	106.0	57.6	-	70.6	89.3
9. Chickmagalur	123.1	37.0	89.4	49.6	86.8	-	75.9	84.4
10. Chitradurga	67.8	32.0	71.1	67.0	78.9	-	73.9	71.2
11. D. Kannada	104.9	50.0	80.8	76.2	107.1	-	76.3	84.6
12. Dharwad	91.29	107.0	61.7	87.0	82.6	-	71.5	99.7
13. Hassan	135.3	67.0	90.6	97.0	109.3	-	96.0	104.0
14. Kodagu	132.4	62.0	107.1	105.6	99.6	-	104.9	96.0
15. Kolar	114.2	83.0	58.4	79.0	86.7	-	81.9	96.4
16. Mandya	110.0	41.0	91.6	84.0	87.5	-	87.0	104.0
17. Mysore	104.2	57.0	84.9	98.9	111.7	-	113.6	103.0
18. Shimoga	100.3	42.0	91.8	86.0	93.5	-	72.5	82.0
19. Tumkur	107.9	68.0	87.7	77.0	105.4	-	90.2	101.0
20. U.Kannada	121.9	88.4	66.5	71.0	61.7	-	69.1	81.8
STATE	104.5	-	84.6	-	90.1	-	83.0	-







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Table - 28 B

Performance Under BCG Immunization Programme in ICDS and Non-ICDS Taluks

Sl.No District	1985-86		1986-87		1987-88		1988-89	
	ICDS		ICDS		ICDS		ICDS	
	Dist.Ach.	Tqs.Ach.	Dist.Ach.	Tqs.Ach.	Dist.Ach.	Tqs.Ach.	Dist.Ach.	Tqs.Ach.
1. Gulbarga	78.9	53.4	107.7	97.2	86.6	73.2	92.5	73.2
2. Raichur	63.0	64.9	94.0	124.4	117.5	90.2	103.2	98.1
3. Bangalore (U)	74.5	55.0	96.8	86.0	168.4	-	82.9	86.0
4. Bangalore (R)	14.9	75.0	98.7	79.0	110.3	-	92.8	87.3
5. Belgaum	75.4	77.0	81.5	76.0	91.5	84.4	97.0	81.7
6. Bellary	83.9	76.0	100.3	75.0	109.7	92.9	86.2	105.0
7. Bidar	83.9	163.1	96.5	87.9	96.7	85.4	98.7	88.7
8. Bijapur	64.6	53.0	106.7	126.0	74.4	95.2	87.3	104.0
9. Chickmagalur	59.4	47.0	97.3	77.0	118.3	-	87.0	102.0
10. Chitradurga	47.9	41.0	70.7	83.0	84.9	-	79.4	96.2
11. D. Kannada	71.8	66.1	80.1	79.5	129.4	-	86.6	96.6
12. Dharwad	50.0	71.0	75.6	107.0	97.1	-	88.6	99.7
13. Hassan	125.9	89.0	98.5	95.0	118.0	-	107.9	143.0
14. Kodagu	94.8	70.0	115.9	109.0	121.7	-	108.6	102.0
15. Kolar	118.0	98.0	71.6	68.0	110.2	-	92.9	117.0
16. Mandya	113.4	83.0	78.9	112.0	115.2	-	99.6	121.0
17. Mysore	61.8	68.0	56.2	108.0	113.4	-	138.1	121.0
18. Shimoga	56.8	70.0	89.7	130.0	102.5	-	89.0	109.0
19. Tumkur	72.7	62.0	82.9	97.0	101.6	-	92.7	123.0
20. U.Kannada	87.0	52.0	114.1	142.0	61.5	147	85.8	113.0
STATE	72.3	-	88.1	-	98.6	-	93.6	-







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Table - 29  
Vaccination Coverage(%) found in Evaluation Surveys Vis-a-Vis Achievements Reported by the Districts

District & Year of Survey	Year of Intro. of UIP	DPT		BCG		MEASLES		TTPW	
		Survey	Ach. Reported	Survey Findings	Ach. reported	Survey Findings	Ach. Reported	Survey Findings	Ach. Findings
Channarayana	1985	88-89	59(85-86)	83.4	71	-	-	-	76.3(85-86)
Channarayana	1988	88-89	56.3	111.6	43.2	96.7	28.2	62.2	105.5
Channarayana	Dec 1988	86-87	61.1	61.0	64.5	97.0	32.7	64.7	92.0
Channarayana	1989	86-87	78 (89-90)	74.2	76	(89-90)95.6	62	(89-90)65.6	91.7(89-90)
Channarayana(R)	1989	89-90	76	81.6	72	92.8	38	56.0	93.8
Channarayana(U)	1989	89-90	86	102.1	88	82.9	71	51.9	98.8
Channarayana	1987	87-88	62.3	89.4	51.9	97.3	-	85.7	110.2
Channarayana	1990	87-88	93	84.2	95	93.2	89	65.1	89.9
Channarayana	1988	88-89	60	78.9	53	84.9	30.5	99.5	110.9
Channarayana	1989	89-90	87	-	79	-	51	-	79
Kannada	1988	87-88	73.3	107.1	64.3	129.4	31.4	47.9	99.0
Channarayana	1988	87-88	57.1	82.6	49	97.1	24.3	70.5	92.5
Channarayana	1988	86-87	48.6	77.3	44.8	86.6	29	73.7	86.6
Channarayana	1989	86-87	48	92.4	40	92.5	20	72.2	75.5
Channarayana	1987	85-86	77.6	90.6	75.7	98.5	45.2	-	63.3
Channarayana	1988	85-86	80	109.3	88	118.8	63	103.9	123.3
Channarayana	1990	85-86	86	101.7	90	106.7	63	87.8	108.6
Channarayana	1987	85-86	67.3	58.4	72.9	71.6	32	-	72
Channarayana	1988	85-86	82.9	86.7	76.8	110.2	50.2	78.8	82.0
Channarayana	1988	87-88	62.8	87.5	70	115.2	27.6	76.6	108.8
Channarayana	Dec 1989	87-88	89 (89-90)	85.0	87	98.8	66	(89-90)73.1	86.4(89-90)
Channarayana	1989	89-90	82	113.6	74	133.1	54	92.8	109.7
Channarayana	1988	87-88	31.9	101.4	27.6	117.5	19.5	88.5	98.1
Channarayana	1988	88-89	73.3	93.5	62.5	102.5	43.8	96.3	106.2
Channarayana	1987	87-88	31	87.7	38.6	82.9	21	-	46.7
Channarayana	1989	87-88	76.67	90.2	71.9	92.7	54.29	70.7	86.2
Channarayana	1988	88-89	32.6	89.9	41.4	109.7	10.2	135.1	110.0
Kannada	1988	87-88	73.5	61.7	55.2	61.5	34.8	32.7	81

In case of Raichur district the Vaccination Survey of 1988 showed coverage of about 31% for DPT and BCG and nearly 50% for pregnant mothers. In Raichur district also, it was reported that a major effort being made in 1990-91 to achieve full coverage.

Vaccine potency in almost all districts brought under UIP has been found to be of high order in almost all samples taken for test- from point at storage of PHCs, to the periphery.\*

Source: Technology Mission on Immunization, Govt. of Karnataka, 1990







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62. The beneficiary survey in a limited number of villages (9 villages) of which all but one were remote from PHC headquarter village showed that immunization coverage for the third dose of DPT was 81% in the ICDS Project areas of two districts (being 80.6% in five villages of Gulbarga, and 81.3 in four villages of Raichur, 61% for Measles and 72.3% for BCG. (Refer Chapter V).

63. To summarize, the trends of immunization coverage in the State, particularly after introduction of UIP, showed substantial improvement in coverages to satisfactory levels in almost all districts, except Gulbarga, by 1989. The findings of beneficiary survey conducted by the study team showed that population coverage had probably improved greatly during 1990 in Gulbarga and Raichur districts also. Also it appeared that, with UIP, the ICDS staff and infrastructure at village was being utilized better to achieve coverage, as shown by better DPT coverage in ICDS taluks of the districts, after introduction of UIP.

#### VITAMIN A ADMINISTRATION AGAINST NUTRITIONAL BLINDNESS

*The performance of the Vitamin A administration programme in the districts of the State and particularly the comparative performance in the ICDS taluks and non-ICDS taluks is presented. The findings on Vitamin A administration to children above one year in the beneficiary families interviewed is also presented together with comments and conclusions.*

64. The district wise coverage of Vitamin A prophylaxis is indicated in Table 30. Overall, the achievement has been around 82% of targeted children since 1987-88. In 89-90, the second dose of Vitamin A was not delivered to children since supplies were not received from the Centre. The reported achievement of Gulbarga and Raichur districts shows that the Programme performance in these two districts is more or less similar to the State average, around 80-90% of children are protected against nutritional blindness by prophylactic Vitamin A.

65. Since the ICDS programme is expected to have a positive influence on the Programme of Vitamin A administration, the districtwise achievements were studied separately for ICDS and non-ICDS taluks to observe the influence of ICDS on programme achievement. Table 81 shows the comparison of Vitamin A administration in the ICDS and non-ICDS taluks. No definite pattern could be observed regarding the influence of ICDS on Vitamin A administration. The coverage in both categories of taluks was more or less similar in all districts.







66. Among the ICDS beneficiaries interviewed in the beneficiary survey in the two districts, the responses by the beneficiaries showed that in the nine villages covered by the survey, 31% of 368 ICDS beneficiary children above one year were administered Vitamin A (This proportion was 32.6% in Gulbarga and 30.6% in case of Raichur). These proportions are far lower than the coverage reported by the Districts.)

67. To summarize, from the State level data, it is difficult to draw definite conclusions on coverage of children for Vitamin A administration, since no data other than performance statistics reported by the districts was available. The coverage in the ICDS taluks of the two districts of Gulbarga and Raichur, in the villages studied, was found to be far lower than the reported district coverage.

**Table - 30**  
**Districtwise Performance of Vitamin A Administration to Children in Karnataka State**

District	1989-90	1988-89	1987-88
	% Ach (Ach.No.)	% Ach. (Ach.No.)	% Ach. (Ach.No.)
1. Gulbarga	76.6 (1,33,123)	74.5 (1,29,446)	86.6 (1,38,488)
2. Raichur	87.2 (1,58,735)	91.7 (1,66,932)	96.7 (1,74,107)
3. Bangalore (U)	73.3% (60,641)	77.6 (64,124)	80.1 (54,445)
4. Bangalore (R)	85.4 (1,24,721)	90.6 (1,32,355)	84.9 (1,12,042)
5. Belgaum	81.5 (2,27,810)	86.1 (2,40,750)	80.5 (1,93,301)
6. Bellary	93.4 (1,06,881)	96.3 (1,10,224)	94.9 (1,09,120)
7. Bidar	80.8 (69,825)	89.4 (77,234)	96.4 (95,431)
8. Bijapur	81.2 (1,78,628)	71.4 (1,57,149)	74.1 (1,62,928)





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9. Chickmagalur	98.0 (72,203)	99.5 (73,328)	90.4 (81,322)
10. Chitradurga	87.3 (1,45,344)	78.2 (1,30,169)	79.0 (1,18,530)
11. D. Kannada	75.3 (1,72,510)	73.6 (1,68,547)	73.9 (1,59,533)
12. Dharwad	89.3 (1,92,065)	93.7 (2,01,592)	94.4 (1,88,852)
13. Hassan	89.1 (1,09,917)	94.2 (1,16,228)	94.7 (1,23,047)
14. Kodagu	88.7 (37,105)	102.7 (42,978)	95.6 (38,250)
15. Kolar	75.3 (1,43,292)	64.1 (1,22,125)	69.7 (1,11,594)
16. Mandya	87.8 (1,10,868)	97.3 (1,22,886)	92.2 (1,19,833)
17. Mysore	73.8 (1,62,264)	86.7 (1,90,675)	90.1 (1,98,129)
18. Shimoga	87.0 (1,24,815)	88.2 (1,26,538)	87.6 (1,31,478)
19. Tumkur	71.9 (1,39,425)	79.5 (1,54,086)	75.4 (1,35,731)
20. U. Kannada	85.8 (75,675)	86.7 (76,463)	90.8 (90,806)
STATE	82.2 (25,60,594)	82.4 (25,67,969)	85.2 (25,56,540)

However, keeping in view the comparatively good performance of immunization in these very villages, the coverage found in beneficiary survey could be considered a fairly accurate indicator of the relative performance of Vitamin A programme in comparison with the Immunization programme in these two districts.





Table-31  
Comparative Data on Vitamin A Administration in ICDS and non-ICDS  
Taluks during 1987-88 to 89-90  
Coverage of Vitamin A (%)

District	ICDS Taluks			Non-ICDS Taluks		
	87-88	88-89	89-90	87 -88	88-89	89-90
1. Gulbarga	115.5	83.2	92.5	70.2	79.5	82.9
2. Raichur	95.8	81.6	95.0	97.7	84.6	87.4
3. Bidar	93.8	92.7	86.4	-	-	-
4. Bellary	96.0	75.7	60.1	97.4	86.2	69.2
5. Bijapur	68.7	76.0	94.7	74.5	75.9	86.3
6. Dharwad	106.1	87.9	86.5	106.0	93.8	83.4
7. Shimoga	119.8	111.7	87.4	79.9	102.9	86.4
8. Belgaum	81.2	81.2	73.8	90.2	72.9	68.7
9. Hassan	192.8	95.4	91.8	96.9	82.2	89.8
10. Chitradurga	79.0	77.6	88.0	80.0	94.2	87.0
11. Bangalore (U)	91.8	84.2	26.9	83.9	62.2	57.5
12. Bangalore (R)	104.1	85.3	89.0	81.7	78.9	83.9
13. D. Kannada	74.6	66.3	74.2	89.3	70.6	75.2
14. U. Kannada	81.6	79.8	89.8	90.3	75.5	84.5
15. Chikmagalur	87.0	99.3	94.2	91.7	78.9	86.6
16. Tumkur	80.9	93.1	82.6	83.9	84.9	67.8
17. Mandya	103.4	90.9	87.0	88.4	92.5	102.9
18. Kodagu	-	-	-	98.8	86.1	85.6
19. Mysore	90.5	75.7	53.8	84.4	79.3	45.9
20. Kolar	89.6	75.3	65.4	80.8	92.5	92.3
STATE TOTAL	96.6	73.5	79.8	87.8	81.8	79.3







## PROPHYLAXIS AGAINST NUTRITIONAL ANEMIA

*The performance of the iron and folic acid distribution programme against nutritional anemia in mothers and children, at the State level is presented. Analysis of the comparative performance between ICDS and Non-ICDS taluks could not be done since data was not available on these lines. The findings of coverage of mother and child beneficiaries in the beneficiary survey carried out during the study are also presented:*

68. The yearwise progress under prophylaxis against nutritional anemia for mothers and children during the years 1985-86 upto 1989-90, is indicated in Tables 32 and 33 respectively. Overall, the reports were that administration of Iron and Folic Acid for the mother beneficiaries was very high, exceeding 100% from 1988-89 onwards. In case of child beneficiaries there has been a shortfall of achievement. The pattern of shortfall during the years 1985-86 to 1989-90 is widely fluctuating between districts and in the same district from year to year, and no definite pattern of achievement could be observed in the districts. For the State as a whole, the achievement in respect of mother beneficiaries was reported to be 116.6% of target, and 48.8% of targetted children in respect of child beneficiaries in 1989-90.

69. In Gulbarga and Raichur districts, the achievement reported in respect of mother beneficiaries was 86% and 65.5% respectively in 1989-90, and 41.5% and 25.4% respectively in case of child beneficiaries in 1989-90. The pattern of achievement over the years in these two districts also shows wide fluctuation from year to year, and as such it is difficult to draw any definite inferences from the data reported from the districts.

70. The coverage of mothers (during their current or last pregnancy) and children in ICDS beneficiary families, for iron and folic acid distribution was elicited during the beneficiary survey (Refer Chapter V). It was found in the selected villages, that 25% of mother beneficiaries (closely parallel with the second dose of tetanus toxoid coverage rate) were provided iron and folic acid. Among children, coverage was negligible, being 4%. Again the relative differences in coverage for immunization which was being vigorously implemented in the current year, and the anemia prophylaxis in the same villages, is perhaps an indication of the relative priority being given to this Programme at the field level.







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Table -32  
Progress under Prophylaxis against Nutritional Anemia during the years  
1985-86 to 1989-90 by Districts - Mother Beneficiaries

Sl.No. District	1985-86 % Ach. (Number)	1986-87 % Ach. (Number)	1987-88 % Ach. (Number)	1988-89 % Ach. (Number)	1989-90 % Ach. (Number)
1. Gulbarga	106.5 (50288)	66.3 (44577)	101.7 (68416)	89.3 (63843)	86.0 (57932)
2. Raichur	103.3 (39271)	74.5 (42966)	94.6 (54519)	65.6 (46769)	65.6 (38831)
3. Bangalore (U)	112.7 (79997)	101.8 (96112)	105.7 (119316)	91.6 (106415)	94.6 (93540)
4. Bangalore (R)	90.4 (44570)	92.2 (603444)	103.2 (48455)	88.5 (44287)	124.9 (58773)
5. Chitradurga	90.0 (42782)	103.3 (59306)	114.3 (65636)	111.3 (67943)	127.7 (74019)
6. Kolar	57.0 (27039)	60.2 (37086)	86.4 (53203)	93.3 (61098)	107.4 (67876)
7. Shimoga	107.4 (43276)	95.2 (50982)	113.8 (60920)	118.4 (67404)	153.1 (84826)
8. Tumkur	91.8 (44162)	95.4 (60993)	108.7 (69457)	98.7 (67063)	123.4 (80446)
9. Belgaum	86.5 (63003 )	54.2 (52214)	60.5 (58228)	72.0 (73726)	107.9 (105416)
10. Bijapur	95.6 (55614)	81.7 (63445)	78.6 (61022)	80.7 (66600)	131.7 (102652)
11. Dharwad	97.7 (69723)	67.2 (63969)	93.7 (89150)	97.0 (98171)	108.3 (105883)
12. U. Kannada	120.9 (31439)	85.2 (29527)	101.4 (35122)	128.5 (47331)	149.4 (53306)
13. Bellary	91.0 (31854)	72.1 (34703)	95.5 (45942)	70.9 (36255)	86.4 (44006)
14. Bidar	53.6 (16092)	113.7 (36573)	81.2 (26128)	88.2 (28331)	80.4 (25986)

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15. Chikmagalur	103.4 (22690)	105.3 (31028)	131.7 (38721)	122.0 (38224)	142.3 (42635)
16. D. Kannada	99.1 (57091)	83.1 (63851)	103.1 (79157)	115.3 (94163)	122.9 (95499)
17. Hassan	101.2 (34100)	99.2 (43473)	119.0 (52163)	114.5 (53406)	143.2 (63955)
18. Kodagu	133.3 (14933)	102.3 (15259)	158.8 (22796)	147.2 (23367)	186.8 (24428)
19. Mandya	101.5 (35033)	99.1 (45503)	137.9 (63337)	129.3 (62971)	135.0 (62631)
20. Mysore	89.8 (56450)	59.0 (49464)	89.5 (75063)	67.6 (60324)	145.1 (116355)
STATE	95.5 (859677)	81.7 (980274)	98.8 (1186752)	100.6 (1207691)	116.6 (1398994)

Table - 33

Progress Under Prophylaxis Against Nutritional Anemia During the Year  
1985-86 to 1989-90 by District Child Beneficiaries

Sl.No. District	1985-86 % Ach. (Number)	1986-87 % Ach. (Number)	1987-88 % Ach. (Number)	1988-89 % Ach. (Number)	1989-90 % Ach. (Number)
1. Gulbarga	89.7 (42358)	41.7 (28035)	65.6 (46928)	22.4 (39927)	41.5 (69943)
2. Raichur	104.0 (39513)	51.1 (29431)	68.2 (48596)	28.0 (49786)	25.4 (37676)
3. Bangalore (U)	106.2 (75406)	84.6 (79930)	81.0 (97150)	44.1 (92222)	32.0 (79224)
4. Bangalore (R)	83.1 (40973)	63.2 (41379)	77.7 (38892)	23.0 (28743)	33.5 (39394)
5. Chitradurga	67.0 (28963)	72.0 (39178)	76.2 (46513)	37.4 (49423)	38.2 (56656)
6. Kolar	71.2 (33769)	54.8 (33752)	71.0 (46448)	38.8 (53968)	38.5 (60862)







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7. Shimoga	86.1 (34703)	74.2 (38707)	87.2 (49620)	41.0 (50077)	56.8 (78719)
8. Tumkur	83.1 (39949)	46.7 (29869)	90.8 (61725)	33.3 (49592)	54.7 (89064)
9. Belgaum	82.6 (60156)	37.3 (35940)	67.7 (68274)	24.2 (58188)	34.4 (84053)
10. Bijapur	92.9 (54044)	51.1 (39652)	60.6 (50020)	27.4 (54872)	44.9 (87516)
11. Dharwad	97.2 (69384)	46.6 (44386)	70.1 (70897)	39.9 (96518)	42.3 (103483)
12. U. Kannada	103.1 (26793)	62.9 (21798)	91.7 (33781)	49.1 (45192)	76.8 (68500)
13. Bellary	86.8 (30370)	60.4 (29065)	82.3 (42121)	36.9 (46897)	50.5 (64338)
14. Bidar	61.4 (18419)	82.9 (26667)	79.8 (27308)	32.9 (28002)	27.6 (22313)
15. Chikmagalur	90.8 (20162)	72.2 (21289)	88.4 (27701)	38.0 (29676)	61.3 (45924)
16. D. Kannada	85.8 (49417)	68.2 (52365)	74.9 (61206)	33.7 (68680)	53.0 (102987)
17. Hassan	94.4 (31804)	90.8 (39810)	109.6 (51154)	60.2 (69793)	113.3 (126506)
18. Kodagu	115.8 (12965)	104.9 (15647)	119.7 (19002)	69.4 (27057)	83.8 (27398)
19. Mandya	83.0 (28719)	64.8 (29749)	103.4 (50393)	49.7 (60148)	39.5 (89235)
20. Mysore	87.8 (55212)	39.0 (32744)	90.8 (80782)	27.2 (60958)	65.2 (130613)
STATE	88.1 (793079)	66.0 (720373)	79.8 (1018471)	35.3 (1059719)	48.8 (1464404)





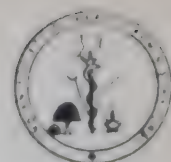


## SPECIAL NUTRITION PROGRAMME

71. The Special Nutrition Programme was initiated in Karnataka in 1970-71 and it was steadily expanded until by 1980, the urban component of the programme was covering 2.3 lakh beneficiaries through 1,136 feeding centres in 55 towns in Karnataka. Subsequently, with the gradual expansion of ICDS, the SNP centres in towns covered by ICDS are being closed down, and by 1989-90, the total coverage in the urban SNP Programme of Karnataka was being extended to 1,72,824 beneficiaries.
72. In Gulbarga district, a total of 4904 beneficiaries limited to the towns of Shahabad, Yadgir and Chittapur are being covered. (Chittapur and Yadgir are State Sector ICDS Projects where the number of Anganwadis are limited to 100 therefore these taluk headquarter towns are being provided supplementary food under SNP Programme while the rural areas are being provided the benefit of ICDS. Gulbarga's share of SNP beneficiaries among the total State beneficiaries works out to 2.7%. However, since most of the urban slum population are being covered under ICDS which is a more systematically planned Programme, the reduction in number of SNP beneficiaries in Gulbarga, is a sign of change over to the better Programme.
73. In Raichur district, five taluks are not yet covered under ICDS as compared with four taluks covered under ICDS. The result is that, under SNP programme the number of beneficiaries in Raichur is higher; 17,270 beneficiaries in the taluk headquarter towns of the non-ICDS taluks are being covered under the Programme. Raichur's share of SNP beneficiaries in the State is about 10%.
74. The budgetary expenditure on food items in Raichur under SNP was Rs.30,90,920 in 1989-90. This worked out to Rs.70.87 per beneficiary per year which further worked out to approximately 24 paisae being spent per beneficiary per day (considering average number of feeding days as 300 days per year). This expenditure is almost half of what is being incurred under the ICDS Programme, and as such one would expect a more limited impact of SNP on women and children's health as compared with ICDS.
75. The follow-up details of SNP beneficiaries and details of beneficiary utilization of SNP is not available, and therefore it is difficult to estimate the possible impact of the programme. However it was expressed that in places where Energy Food was being distributed under SNP, it was not acceptable to the people and therefore not many beneficiaries were interested to avail the food supplements. It was strongly felt that the SNP areas should be brought under ICDS coverage, and locally acceptable food should be provided.







## SCHOOL MID-DAY MEAL PROGRAMME

The objective of this review is to assess how far the objectives of the Programme are being achieved. At the State level, detailed information on districtwise primary school enrollment rate and the ratio of children enrolled in Class IV; Class I is available from 1980-81 onwards. An attempt has been made to correlate these items of data, with the beneficiary coverage in the Mid-day Meal Programme in the districts, to study the possible impact of the Mid-day meal programme on school enrollment and continuation of education by Students. An attempt is also made to assess whether the districts are being covered according to need for the programme.

In the Study Districts of Gulbarga and Raichur, a study of the implementation, impact and need for the Programme in these two districts was carried out. The Asst Education Officer is in charge of Programme implementation in the taluk, which is the unit of implementation of the Mid-day meal Programme. Four taluks - two in Gulbarga and two in Raichur were studied for school enrollment with the help of data from the office of the Asst. Education Officer, as also mid-day meal coverage; a sample of schools was visited for nutritional assessment of school children and interviews.

### 76. Progress of Implementation in the State Since 1963-64 to 1988-89

The school Mid-day Meal Programme beginning with 3.12 lakh (school children) beneficiaries in 1963-64 with CARE food assistance, increased its coverage until 1972-73, and thereafter CARE assistance was gradually withdrawn. From 1980-81 onwards, the State Government, keeping in view the programme objectives, decided to step in and started providing Energy Food Supplement to keep up the number of beneficiaries to about 12 lakh school going children. This amounted to 32.3% of the Primary School children enrolled. By 1988-89, 12 lakh beneficiaries were being provided with the Mid-day Meal, serving 32.17% of primary school children enrolled. The progress with regard to number of beneficiaries from 1963-64 upto 1989 is indicated in Table 34.





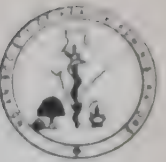


Table -34  
Beneficiaries Under CARE and Energy Food Since 1963-64  
(Number in lakhs)

Years	CARE	Energy Food Programme
1963-64	3.12	-
1964-65	3.95	-
1965-66	4.62	-
1966-67	5.31	-
1967-68	7.34	-
1968-69	10.41	-
1969-70	11.48	-
1970-71	11.48	-
1971-72	10.63	-
1972-73	11.74	-
1973-74	8.47	-
1974-75	6.48	-
1975-76	6.00	-
1976-77	9.00	-
1977-78	5.40	-
1978-79	8.50	-
1979-80	10.50	1.80
1980-81	8.97	2.40
1981-82	7.62	2.90
1982-83	7.62	3.00
1983-84	7.62	4.00
1984-85	7.00	5.00
1985-86	7.00	5.00
1986-87	7.00	5.00
1987-88	7.00	5.00
1988-89	7.00	5.00

#### 77. Progress in Coverage of SC/ST beneficiaries

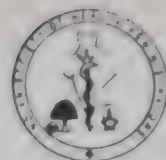
The coverage of the programme for SC/ST beneficiaries over the years is given in Table 35. It shows that 26.29% of beneficiaries under CARE assistance and 28.25% of beneficiaries under Energy Food belonged to SC/ST, which is far more than the proportions of SC/ST enrolled in schools, suggesting that the Programme is specifically reaching out more to these groups.

#### 78. Average Cost to the State per Beneficiary

The State has been increasing the budget expenditure in the Programme since 1980-81 as the State Government's liability on account of providing Energy Food in place of CARE food, is increasing.







The annual expenditure per beneficiary in CARE programme is more or less static at Rs.18.20; whereas the expenditure per beneficiary in Energy Food is decreasing year by year. It was Rs.82.40 in 1982-83, Rs.101.67 in 1983-84 and thereafter decreasing till it was Rs.76.40 in 1987-88. This was explained to be due to decrease in number of feeding days per year.

#### 79. Number of Feeding Days per year

The number of feeding days per year has been steadily going down. It is normally expected that on about 200 days, mid-day meal should be provided. However, the number of feeding days has been far less. It was 160 days in 1982-83, 167 days in 1984-85 and gradually coming down, until in 1989-90 it was 110 days only.

#### 80. Districtwise Coverage of School Children for Mid-day Meal

Table 36 shows the districtwise coverage of school children for the mid-day meal during 1988-89 (the proportions of children covered for the programme were reported to have been more or less constant since 1980-81). The average coverage of school children ranged from 23.3% of school children in Shimoga to 50.8% of school children in Bidar (excluding the urban Bangalore and Mysore which are not comparable for many reasons).

It is observed that, generally not much difference in coverage of school children is seen from district to district.

#### 81. Districtwise School Enrollment Rate

The districtwise primary school enrollment rates (enrollment as a proportion of enumerated children) in 1982-83, 84-85, 86-87 and 88-89 are given in Table 37. From this table, no difference in school enrollment rate in the districts is obvious from the year 1982-83 to 1988-89. It has been around 85-98% of enumerated children in the age group 5-10 years.

Overall, the comparison of school enrollment rate with the percentage of school children covered under Mid-day Meal Programme in the respective district, does not show any correlation.

82. Districtwise School retention of Students upto Class IV was attempted to be studied through the Class IV to Class I ratio in any given year. This Class IV to I ratio (which should ideally be very high) for the years 1982-83 and 1988-89 is indicated in Table 38. The objective was to study its correlation with coverage of school children for mid-day meal, whether the districts with higher coverage were showing relatively higher proportion of students in Class-IV (which

Table -35







Table -35  
SC & ST Beneficiaries Under CARE and Energy Food Programmes  
1980-81 to 1988-89

Year	Total Beneficiaries in lakhs	SC & ST Beneficiaries Number in lakhs	% of total beneficiaries
<b>CARE Programme</b>			
1980-81	14.30	3.78	26.43
1981-82	12.68	3.35	26.42
1982-83	11.33	2.99	26.39
1983-84	9.53	2.45	25.71
1984-85	7.62	1.90	24.93
1985-86	7.00	1.83	26.14
1986-87	7.00	1.74	24.86
1987-88	7.00	1.71	24.43
1988-89	7.00	1.84	26.29
<b>Energy Food Programme</b>			
1980-81	1.87	0.39	20.86
1981-82	2.40	0.43	17.92
1982-83	2.90	0.63	21.72
1983-84	3.00	0.69	23.00
1984-85	4.00	0.94	23.50
1985-86	5.00	1.37	27.40
1986-87	5.00	1.39	27.80
1987-88	5.00	1.48	29.60
1988-89	5.00	1.55	31.00
1988-89 CARE + Energy Food	12.00	3.39	28.25

which would indirectly indicate the influence of the mid-day meal programme in attracting the children to remain in school). No correlation could be found between proportion of children covered by mid-day meal programme and the Class IV: Class I ratio in the respective districts. On closer observation, it was observed that the Class IV: Class I ratio (in 1988-89) was lower in the traditionally backward districts; 18.4 in Gulbarga district 38.6 in Tumkur district and around 50% in Raichur, Chitradurga, Dharwad, Bidar, Bijapur, and Uttara Kannada. It was very high (thereby possibly indicative of a low drop out rate) in Shimoga, Dakshina Kannada, Kodagu and Chickmagalur.







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Table-36-  
Districtwise Number of Beneficiaries under CARE and Energy Food  
Programmes 1988-89

District	Total Beneficiaries			Total No. of stu- dents Class I-IV	Benefit by Mid- day Meal
	CARE Food	Energy Food	Total		
1. Bangalore(N)	-	15,000	15,000	1,12,160	13.4
2. Bangalore(S)	-	21,000	21,000	1,24,035	16.9
3. Bangalore(R)	45,500	17,000	62,500	2,04,190	30.6
4. Belgaum	40,500	43,000	83,500	2,86,190	29.2
5. Bellary	27,000	15,000	42,000	1,37,640	30.5
6. Bidar	45,000	-	45,000	88,570	50.8
7. Bijapur	63,000	22,000	85,000	2,79,170	30.4
8. Chickmagalur	27,500	7,000	34,500	1,02,932	33.5
9. Chitradurga	42,000	15,000	57,000	1,93,475	29.5
10. Dharwad	57,000	46,000	103,000	2,44,310	42.2
11. Gulbarga	63,000	-	63,000	1,95,976	32.1
12. Hassan	44,000	5,000	49,000	1,32,240	37.0
13. Kolar	43,000	24,000	67,000	1,73,116	38.7
14. Mysore	54,500	40,000	94,500	2,50,860	37.7
15. Mandya	-	43,500	43,000	1,38,288	31.1
16. Kodagu	-	22,000	22,000	46,265	47.6
17. D. Kannada	-	103,000	103,000	3,26,750	31.5
18. U. Kannada	-	44,500	44,500	1,15,025	38.7
19. Raichur	39,000	3,000	42,000	1,67,460	25.1
20. Shimoga	48,000	-	48,000	2,06,380	23.3
21. Tumkur	61,000	14,500	75,500	2,04,795	36.9
State Total				12,00,000	32.17%







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Table - 37  
Districtwise Primary School Enrollment in the State since 1982 to 1989  
(% of Enumerated in brackets)

('000s)

District	82-83	%	84-85	86-87	88-89	%
1. Gulbarga	139629	(91)	113912	116681	203021	(93)
2. Raichur	100055	(82)	90908	92998	222119	(95)
3. Bangalore (S)	116510	(92)	96623	94791	130085	(90)
4. Bangalore (N)	93900	(98)	72908	79512	118930	(91)
5. Bangalore (R)	166117	(93)	133604	138019	214840	(92)
6. Chitradurga	178323	(97)	135358	139173	201455	(95)
7. Shimoga	166361	(91)	134031	121308	210980	(94)
8. Tumkur	190602	(96)	148050	143378	213983	(87)
9. Kolar	170399	(98)	132915	137118	177696	(87)
10. Mysore	219646	(91)	175744	175255	306967	(92)
11. Mandya	147413	(98)	120003	110629	176280	(90)
12. Hassan	133957	(94)	105958	100801	156393	(92)
13. Kodagu	27486	(87)	25791	28101	53415	(91)
14. Chikmagalur	88866	(92)	67013	67716	124866	(94)
15. S. Kanara	195810	(89)	175720	158900	379360	(94)
16. Dharwad	268201	(93)	239029	241427	256520	(92)
17. Bellary	127835	(97)	103142	11570	207552	(94)
18. Belgaum	279196	(99)	225476	232320	298190	(95)
19. Bijapur	241870	(98)	200790	214888	293870	(96)
20. Bidar	73961	(98)	57515	58589	92570	(85)
21. North Kanara	98341	(98)	79209	77028	121475	(90)





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Table - 38  
Class IV : Class I Ratio in 1982-83 and 1988-89 as related to coverage  
for School Mid-day Meal

CARE/Non-CARE districts	Class IV: Class I Ratio 1988-89		Proportion of Children covered for Mid-day Meal(%)
	1982-83	1988-89	
<u>I. CARE Food Dists.</u>			
1. Bangalore (R)	56.4	66.2	30.6
2. Belgaum	82.2	85.2	29.2
3. Bellary	73.8	83.7	30.5
4. Bidar	65.3	51.9	50.8
5. Bijapur	40.9	55.8	30.4
6. Chikmagalur	65.5	91.9	33.5
7. Chitradurga	51	56.1	42.2
8. Dharwad	46	53.5	42.2
9. Gulbarga	72.3	18.4	32.1
10. Hassan	68.6	70.5	37.0
11. Kolar	56.4	68.1	38.7
12. Mysore	60.8	60.6	37.7
13. Raichur	69.9	54.9	31.1
14. Shimoga	59.4	97.9	23.3
15. Tumkur	84.5	38.6	36.9
<u>II. Energy Food Districts</u>			
1. Bangalore City (N)	20.4	66.2	13.4
2. Bangalore City (S)	67.8	67.1	16.9
3. Bangalore (R)	56.4	67.1	13.4
4. Chitradurga	51	56.1	29.5
5. Kolar	56.4	68.1	38.7
6. Belgaum	82.2	85.2	29.2
7. Tumkur	84.5	38.6	36.9
8. Mysore	60.8	60.6	37.7
9. D. Kannada	63.2	98	31.5
10. Kodagu	51.8	114.9	38.7
11. Mandya	40.9	73.9	31.1
12. Bijapur	49.9	55.8	30.4
13. Dharwad	46	53.5	42.2
14. U. Kannada	52.8	48.6	38.7

\* Some districts are partially covered by both CARE and Energy Food







Data on School dropout rate between the mid-day meal programme schools and non-mid-day meal programme schools was not available at the State level. Also, conclusive data was not available at the State level regarding continuation of education of children at schools. The available data on Class IV students districtwise, suggests that continuation of the child in school is subject to several other factors such as general backwardness and other social factors, and is not influenced only by the mid-day meal programme.

### 83. Programme Overview in the Two study Districts Gulbarga and Raichur

Two taluks of each district were selected for reviewing the implementation of the programme as well as assessment of the progress and impact of the programme. In Gulbarga district, Afzalpur and Sedam taluks (both selected at random for study of the ICDS Programme), and in Raichur district, Lingsugur and Deodurg taluk were visited.

*The findings are as follows:*

#### *i) Coverage of School Children for the Mid-day meal Programme*

It was found that the coverage of children for school mid-day meal programme was highest in Afzalpur taluk at 53% of children covered in 89-90 and in the remaining three taluks it was around 25% as shown in Table 39.

#### *ii) Class IV: I ratio in the mid-day meal schools and non-mid-day meal schools in the taluks studied.*

Table 40 shows the comparison of Class IV to Class I ratio in the group of schools with mid-day meal programme, and the group of schools without mid-day meal programme.

The data shows higher ratio of class IV to Class I students in the mid-day meal group of schools than in the non-mid-day group in both the districts in both years. i.e. greater proportion of students in mid-day meal schools were continuing education up to IV standard. This phenomenon was particularly marked in the case of Afzalpur and Deodurg taluks. This finding suggests that Mid-day Meal Programme is indeed able to prevent some dropout that occurs between Class I - IV. This suggests that to some extent, the Programme is achieving one of the objectives, namely, ensuring higher school enrollment, particularly continuation of education atleast upto 4th standard. However this finding needs a detailed state-wise investigation as to whether this finding holds good for the State as a whole, and also whether there are differences in this phenomenon between schools implemented for CARE and Energy Food respectively.







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Table - 39  
Proportion of Primary School children covered for Mid-day Meal  
in the taluks studied

	1988-89			1989-90		
	Total enrol- ed	No. of benefi- ciaries	Proportion of children covered	Total enrol- ed	No. of benefi- ciaries	% school children covered
<u>Gulbarga Dist</u>						
1. Afzalpur	11470	6000	52%	14987	8000	53.3
2. Sedam	12910	3000	23%	14010	3500	25%
<u>Raichur Dist</u>						
1. Deodurg	14475	4000	27%	15690	4000	25.5%
2. Lingsugur	22963	5000	21.7%	25040	5000	25%



Table - 40

Class IV : I Ratio in schools with Mid-day Meal Programme and without Mid-day Meal Programme in the selected taluks of Gulbarga and Raichur districts

Schools with Mid-day Meal Programme				Schools without Mid-day Meal Programme			
1988-89				1989-90			
Districts	Std.I	Std.IV Class IV:I	Std.I Std.IV Class IV:I	Std.I	Std.IV Class IV:I	Std.I Std.IV Class IV:I	Std.I Std.IV Class IV:I
<u>I. Gulbarga District</u>							
1. Afzalpur	2545	1436	56.4	2501	1529	61.1	
2. Sedam	1189	468	39.4	1214	501	41.3	
Total	3734	1904	51	3715	2030	54.6	
<u>II. Raichur Districts</u>							
1. Lingsugar	1208	1120	92.7	1190	900	75.6	
2. Deodurg	1120	497	44.4	1116	479	42.9	
Total II	2328	1617	69.5	2306	1379	59.8	
	6062	3221	53.1	6021	3409	56.6	
						</	



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iii. *Nutritional Status of Children in the Primary Schools of Gulbarga and Raichur Districts:*

For assessment of nutritional status, two mid-day meal schools and one non-mid-day meal school were visited in Gulbarga District, and two mid-day meal schools and two non mid-day meal schools were visited (Ref. Chapter III). In Raichur, a third school with mid-day meal was visited and children assessed but it was found that the mid-day meal was just started in 1990-91, and, after one month's feeding in June there had been a gap and it was resumed only recently. So findings of that school have not been taken into consideration for the study, as this school could not be clearly classified. Nutritional status was assessed by weight for age, height for age, and nutritional deficiency signs.

a) The Nutritional status of children in Class I - IV as assessed by weight for age (Gomez Classification) showed no difference in the schools with mid-day meal or no mid-day meal (Table 41).

b) The nutritional status of children as assessed by height for age (Waterlow's Classification) showed significant difference i.e the proportion of normals and marginally malnourished by height-for-age, of children in the mid-day meal group was higher than in the non mid-day meal group of schools. Table 42 shows the nutritional status by height for age. Further it was observed that this difference was more marked in Gulbarga district.

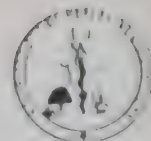
c. The prevalence of clinically evident Vitamin A deficiency (Frank Bitot's Spots were much more prevalent as compared with Conjunctival Xerosis), was significantly higher in the non mid-day meal schools as compared with the mid-day meal schools).

84. To summarize, the observations regarding the mid-day meal programme are as follows:

i) At the State level, the number of beneficiaries covered by the programme has remained static since 1980-81 even though the population and therefore child enrollment, should have gone up substantially. Similarly, the reduction in number of feeding days, reduced utilization of budget per beneficiary, also point to some degree of uncertainty regarding the policy and commitment of the Government to the Mid-day Meal Programme. At this juncture, considering the financial aspect, a clearcut policy decision of the State Government regarding the Programme is needed, based on objective findings of impact of the Programme. If the Programme is judged to have good potential to achieve the objectives, policy decisions are required regarding achieving definite coverage in the State, coverage of specific districts based on factors of literacy, general backwardness, child nutritional status or any other relevant guidelines, and as a corollary, decisions would need to be made on several other aspects of implementation.







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Table - 41  
Nutritional status of students (weight for age) studying in Standards I to IV in selected schools of Gulbarga and Raichur Districts (Gomez Grades)

	Total No. of students assessed	No. of Students with Nutritional Status(weight for age)				Clinical Findings: Number of students having	
		Normal	Gr.I	Gr.II	Gr.III	Bitot's spots	Conjunctival Xerosis
<u>I.Mid-day Meal Programme Schools</u>							
Gulbarga							
1. GHPS (Kannada), Karajgi	48	7	16	21	4	1	1
2. GHPS (Urdu) Karajgi	43	7	16	18	2	1	-
Raichur							
3. GPS,Gorebal	28	3	10	13	2	4	1
4. GHPS,Hemanur	37	3	15	18	1	3	-
Total MMP Schools	156 (100.0)	20 (12.8)	57 (36.5)	70 (44.9)	9 (5.8)	9 (5.8)	2 (1.3)
<u>II. Non Mid-day Meal Programme Schools</u>							
Gulbarga							
5. GPS, Batagerq-K	67	1	17	42	7	9	3
Raichur							
6. GPS,Chinchodi	45	5	21	18	1	5	2
7. GLPS,Gorebal, Thanda	7	1	5	1	-	1	-
Total Non-MMP Schools	119 (100)	7 (5.9)	43 (36.1)	61 (51.3)	8 (6.7)	15 (12.6)	5 (4.2)
<u>III. Mid-day Meal Programme started in 1990-91</u>							
Raichur							
8. GHPS, Hanuman-gudda	63 (100.0)	6 (9.5)	18 (25.4)	37 (58.7)	4 (6.4)	12 (19.0)	2 (3.2)
Total All Schools	338 (100.0)	33 (9.8)	116 (34.3)	168 (49.7)	21 (6.2)	36 (10.7)	9 (2.7)





**Table - 42**  
**Nutritional Status of Students - Height for Age - studying in Standards I to IV in selected Schools of Gulbarga & Raichur districts**  
**(Waterlow's Classification)**

	Number of stu- dents asse- ssed	Nutritional Status of Students			
		Normal	Marginal	Moderate	Severe
-----					
I. <u>MMP Schools</u>					
1. HPS (Kannada) Karajagi	45	25	15	3	2
2. HPS (Urdu), Karajagi	43	19	13	11	-
3. GPS, Gorebal	28	8	10	10	-
4. GHPS, Hemanur	37	7	19	9	2
-----					
Total MMP Schools	153	59 (38.6)	57 (37.2)	33 (21.6)	4 (2.6)
-----					
II. <u>Non-MMP Schools</u>					
5. GPS, Batagere - K	67	5	34	24	4
6. GPS, Chinchodi	45	14	16	15	-
7. GLPS, Gorebal-Thanda	7	3	2	2	-
-----					
Total Non-MMP Schools	119	22 (18.5)	52 (43.7)	41 (34.4)	4 (3.4)
-----					
III. <u>MMP Started in 1990-91</u>					
8. GHPS, Hanumanagudda	63	14 (22.2)	17 (27.0)	23 (36.5)	9 (14.3)
-----					
All schools	335	95 (28.4)	126 (37.6)	97 (29.0)	17 (5.0)

ii) At the State level, however, clearcut evidence is not available on the role of the Programme in ensuring school enrollment, retention of children in schools upto Class IV, nutritional status (no Statewise data available on school children) or scholastic achievement.

iii) The school dropout (as measured indirectly by the Class IV: Class I ratio) appears to be higher in the more backward districts and less in the advanced districts. Thus, it is possible that greater cost benefit may be achieved by greater coverage of school mid-day meal







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programme in the former group as well as other traditionally backward districts with low child nutrition status (Chapter -II). However, more detailed information is required from a sample of districts to draw definite conclusions regarding these aspects.

iv. Within the two districts of Gulbarga and Raichur, the Mid-day Meal Programme appeared to have a beneficial effect in retaining the children in school upto class IV once they were enrolled.

Further the mid-day meal programme appeared to have a beneficial effect on nutritional status particularly in preventing stunting of growth, and also in preventing serious Vitamin -A deficiency in school children in these two districts.

d) The above findings need to be corroborated by a large scale study encompassing the whole State. These findings of the present study suggest that an indepth review of the impact of the programme on a State-wide basis, is certainly worthwhile, since the indications are that the programme may be carrying substantial potential for long term improvement of nutritional status, as well as for improving the literacy of the growing new generations.

#### MATERNITY ALLOWANCE TO AGRICULTURAL LANDLESS WOMEN LABOURERS IN KARNATAKA

*Scheme,*  
85. Under this in the State as a whole, an amount of Rs.141.97 lakhs has spent in 1987-88 covering 41,632 persons; in 1988-89, Rs.401.05 lakhs were spent to cover 1,33,686 women, and during 1989-90, Rs.237.75 lakhs were spent covering 79,252 persons. There were about four million landless women agricultural labourers in the State (1981 Census). From the number of beneficiaries, it is not clear as to what proportion of women labourers in Karnataka delivering their first two children are being covered in each year.

86. In Gulbarga district, 2858 women were provided the maternity allowance in 1988-89 and 3050 in 1989-90, giving an average of approximately five women per PHC per month being given the benefit. In Raichur district 3828 beneficiaries were covered in 1988-89 and 5,925 beneficiaries were provided the allowance in 1989-90.

87. The field observations by the Study team during beneficiary survey of Gulbarga and Raichur districts showed that mostly the poor and landless women were receiving the benefit and also, it was being limited (as per norm) to first two pregnancies only. (Refer Chapter V). It was being chiefly utilized for nutritional purposes. However, it was also observed by the study team, that its long term contribution to maternal health may not be significant, since none of the beneficiary women accepted FP or spacing methods nor was there any







educational effect of this measure regarding mothers health, and these mothers continued to bear the same risk as others, of repeated and many childbirths subsequently. Unless this type of welfare measure is followed up by promoting more long term health measures such as child spacing or permanent sterilization, no long term impact on maternal and child health would be seen. Thus, it would appear that substantial financial liability is being incurred by the State for very short term gain. Also, it was observed that the Anganwadi workers who are chiefly working with the economically and socially weaker sections in the village, are not being involved to identify the beneficiaries. Involvement of the AWW could ensure coverage of the poorest sections.

88. To summarize, the financial liability on account of the maternity allowance programme is high and suggests a need for recasting of the Programme. In case this programme is to be pursued as a clearcut strategic investment in maternal and child health, then:

(i) Firstly, the eligible beneficiary population as per norms would need to be estimated and thrust given for covering most of these women.

ii Secondly, keeping in view the financial involvement, the maternity allowance should become a long term investment for maternal health. Therefore, this allowance should be linked to family planning acceptance, either the intrauterine device or permanent sterilization (since the other methods are unreliable in terms of effective continuation). This would ensure maternal and child health through spacing and limitation of fertility.

iii) Thirdly, the women and child welfare department being predominantly concerned with the weaker sections, and having a village level infrastructure which is already enumerating and working with the poor under the ICDS programme, the Department could be involved in beneficiary identification. The services of the AWW along with the AW supervisor could be utilized to ensure that the scheme reaches out to the poorest of the poor in the villages.

iv) It is desirable that the staff of the Department of Women and Children Welfare should be involved in beneficiary identification jointly with Health Department functionaries. Otherwise, it is difficult for the Women & Children's Welfare Department to resume accountability for a programme, the implementation of which is outside its purview.







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SUBSIDY PROGRAMME FOR INCOME GENERATION ACTIVITIES FOR WOMEN (GRIHA-KALYANA SCHEME)

89. Progress of Implementation

Under this scheme the State Government releases the funds to the districts. The Assistant Director in consultation with the CDPOs decides the allocation to each taluk based on the local beneficiaries response in the previous years and the funds available. The district-wise budget expenditure and number of beneficiaries under this scheme is indicated in Table 43.

Under this scheme, in Gulbarga district a total of 36 women were provided subsidy in 1988-89 and 4 in 1989-90. In Raichur district, a total of 61 women were assisted during 1989-90.

90. Impact of the Programme in the State as a whole

i) It could be observed that very few beneficiaries per taluk are being covered, and thus presently on a State-wide basis it cannot be making much impact on the socioeconomic and health status of women. However, since it involves entrepreneurial skills and abilities of the community, implementation would necessarily be tardy and in tune with the local level of development and women's status in the community.

ii) It was observed that the utilization of budget and beneficiaries covered in all districts in 1987-88 was very low. This was attributed to delayed release of funds by the Zilla Parishads ever since the District level financial power was handed over to Zilla Parishads in 1987-88.

iii) Most of the beneficiaries tended to utilize the loan for petty shops, milch cows, sheep/goat/poultry rearing and other farm related activities.

iv) Overall in the CDPO's experience, majority of loanees repaid the loan. However banks were reluctant to advance small sums to many loanees since it involved lot of work for them to ensure repayment. In this connection, the officials of the Department of Women and Children's Welfare were looking forward to the Karnataka State Women's Development Corporation becoming operational, which would be more oriented to women's development activities.

v) The system of utilizing ICDS staff for identifying eligible persons from the weaker sections has been more or less successful.

vi) Implementation of certain politically based decisions such as the farmer's loan waiver (upto Rs.10,000), has resulted in reluctance to repay loan and also high default rate in the current years.







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## . MAHILA MANDAL SCHEME

91. The working of the Mahila Mandal Scheme was reviewed in the two study districts and the following observations were made:

i) *General:*

Mahila Mandals were reported to be actively involved in women's development activities in the more advanced villages and taluks such as Afzalpur taluk of Gulbarga district. In most other taluks, mahila mandals were formed with the anganwadi worker as secretary who organizes few activities such as mother's meetings and nutrition demonstrations.

ii) In Afzalpur taluk, the working of Mahila Mandals was reviewed. The taluka Mahila Federation had been active for two years. Mostly some work had been done in the taluk headquarter. Ten local poor women were involved in making school uniforms for the Education Department (to be distributed free to all school children). This activity was followed by papad and chilli powder preparation, for supply of which, the Mahila Federation had undertaken a contract with all the schools and colleges and SC/ST hostels in the taluk.

iii. In case of Deodurg taluk, 92 village Mahila Mandals (of total 129 villages) had registered with the Federation. Samuha, a large voluntary organization was reported to have contributed greatly to this development. For 10 Mahila Mandals of the larger villages, a grant of Rs.1500/- each had been made for purchase of sewing machines to teach tailoring skills to village women. In each of these villages, an average of 10 - 30 women had been taught tailoring after charging a monthly fee of Rs.30/- per month (to pay the instructor).

92. Overall, from the picture in these two districts, some sporadic work by Mahila Mandals is apparent. Since many schemes such as the Creche Scheme, depend on the success of Mahila Mandals, a detailed strategy is required for systematically operationalizing the Mahila Mandals.

## CRECHES FOR CHILDREN OF WORKING WOMEN IN RURAL AREAS

93. Under this scheme an amount of Rs.12.38 lakhs were provided to voluntary organizations for running 200 creches. In Raichur district alone, 58 creches have been assisted and in Gulbarga district 6 creches were assisted. It was observed by the CDPOs and Assistant Directors, that frequently, creches take care of less than 10-12 children, and often not even in 25 days for a month.







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In this connection, it was the observation of the study team, that the term voluntary organization in rural areas in the context of Women and Children's Welfare, mostly refers to Mahila Mandals. The Mahila Mandals in the villages are being encouraged and fostered by the ICDS staff, in ICDS areas. In other taluks, Mahila Mandal activity is mostly a sporadic effort. Keeping in view the above scenario, it appears that unless the Department has infrastructure to verify the activities, the utilization of funds provided may or may not be appropriate. Hence, for optimum utilization of resources it may prove advantageous to link up the ICDS activities related to Mahila Mandals, with the scheme for creches so that creches can be sanctioned only in those villages where the Mahila Mandals are becoming effective as verified by the ICDS staff. Otherwise, funds could be provided only in cases of proved well-functioning voluntary organizations.





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Table - 43  
Progress of Income Generation Programme (Grihakalyana Scheme)  
1982-83 to 1987-88

(Amount in Rs)

District		1982-83	1983-84	1984-85	1985-86	1987-88
Bangalore	Amt	129,227.00	113,501.40	298,645.00	229,786.15	-
	Bene	257	202	805	532	
Kolar	Amt	84,780.50	15,000.00	119,401.00	36,645.00	14,775.00
	Bene	107	20	166	45	21
Mysore	Amt	47,506.00	29,787.50	74,553.75	29,478.00	21,434.00
	Bene	133	87	164	61	33
Mandya	Amt	30,062.00	5,962.50	223,902.00	87,318.50	12,800.00
	Bene	44	11	399	135	16
Mysore	Amt	90,900.00	-	106,917.00	229,603.75	81,867.50
	Bene	133		167	253	156
Kannada	Amt	138,946.50	143,827.85	315,271.18	176,454.07	19,175.00
	Bene	393	369	662	333	21
Kodagu	Amt	57,594.21	175,155.72	148,955.45	31,017.80	3,000.00
	Bene	106	422	224	45	9
Kannara	Amt	27,907.50	16,100.00	110,687.15	64,350.00	17,500.00
	Bene	99	18	316	203	20
Chikmagalur	Amt	15,022.50	6,671.75	49,620.25	75,380.00	6,750.00
	Bene	22	19	97	115	7
Chitradurga	Amt	80,658.50	8,925.00	137,988.75	135,155.00	9,150.00
	Bene	161	14	227	274	15







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Shimoga	Amt	9,722.25	28,688.25	198,761.50	104,477.50	10,862.50
	Bene	23	62	305	162	26
Hassan	Amt	35,362.60	8,138.50	56,410.25	18,374.65	8,500.00
	Bene	73	12	130	16	28
Dharwad	Amt	122,625.00	9,500.00	138,750.50	37,926.25	26,775.00
	Bene	211	19	284	77	44
Bijapur	Amt	95,750.00	20,000.00	117,165.00	55,065.00	32,250.00
	Bene	188	50	178	99	52
Belgaum	Amt	62,000.00	-	49,325.00	21,308.75	22,150.00
	Bene	137	-	102	45	31
Bellary	Amt	35,825.00	17,995.00	73,637.50	37,862.50	32,875.00
	Bene	89	29	172	76	70
Aichur	Amt	46,000.00	17,975.00	54,268.75	33,785.00	14,000.00
	Bene	114	29	143	86	22
Bidar	Amt	119,504.75	13,625.00	41,410.00	61,600.00	9,300.00
	Bene	267	16	211	269	32
Bulbarga	Amt	51,637.50	5,450.00	37,920.84	33,928.25	13,325.00
	Bene	244	24	148	85	36
Bangalore-R	Amt	-	-	-	-	30,999.25
	Bene	-	-	-	-	39
Bangalore-U	Amt	-	-	-	-	29,512.00
	Bene	-	-	-	-	36

Bene - Beneficiaries







## Chapter V

## OUTREACH OF THE PROGRAMMES AND COMMUNITY UTILIZATION OF THE SERVICES

*In this chapter, the outreach of the ICDS services, outreach of immunization, Vitamin A and iron and folic acid administration services, and outreach of the Maternity Allowance Programme are presented, as gathered during the beneficiary survey carried out in nine of the ten villages selected. In addition to outreach of services of the different programmes, information was also collected on other practices which influence maternal and child health and nutritional status namely - family diet, maternal and child nutrition practices, child care, sanitation and personal hygiene. Also, the role of health education in changing practices in the villages, was also attempted to be collected in the beneficiary survey.*

In each village, on an average, 20 ICDS beneficiary families were contacted and information could be compiled from a total of 175 completed family interviews. In addition, 43 families not covered for SNP were also interviewed to study differences in the above practices in the two groups of families. The following paragraphs summarize the findings of the survey.

**I. INCOME CHARACTERISTICS OF THE BENEFICIARIES**

The income profile of the ICDS beneficiary households showed that 80% of the households had a family income below Rs.6,000/- per annum and in fact 40% had an annual income below Rs.3,000/- and thus belonged to the poor or very poor sections. 13.1% were classified in the middle income group of Rs.6,000/- - 12,000/- . Only 4.6% had an income beyond Rs.12,000/- per annum. 17.8% of the beneficiaries contacted belonged to scheduled castes. Income-wise, it could be observed that the ICDS programme was reaching out mostly to the poorest and the poor.

**II. PROPORTION OF ELIGIBLE POPULATION ACTUALLY AVAILING SUPPLEMENTARY NUTRITION DAILY**

The average number of children per family was 3.47 giving an average household size of 5.47. There were 368 children above one year and under six years of age, (reported by 175 beneficiary fami-







lies) of which 278 (75.5%) were availing supplementary nutrition at the Anganwadi daily. Most of the children who were not sent daily to the Anganwadi were young children whom parents carried with themselves to the fields, since the child would be unattended after 1-00 PM when the Anganawadi was closed.

Among the total 255 eligible couples contacted, 22 women were currently pregnant and 97 were currently lactating (delivered less than six months ago). Only five expectant mothers and three lactating mothers reported that they were taking supplementary nutrition regularly at the Anganwadis. Thus the utilization of the SNP by these two groups could be considered as negligible.

### III. REASONS FOR SENDING CHILDREN TO ANGANWADI

The reasons for sending children to the Anganwadi were elicited, to assess whether the community is aware of the multiple benefits of sending the children to Anganwadi, or whether they were only sending the children for the purpose of food. 25% of families indicated preschool education as the primary reason to send the children, 30.9% indicated preschool education and food as the motivating factors to send the children; 19.4%, food only as the reason (this response was mostly seen in the villages with infrequently supervised Anganwadis); 21.7% indicated food and baby-sitting during their work hours as the reasons, and only 2.9% indicated that nutritious food served and learning of hygienic habits at anganwadi was the motivating factor.

Thus, overall it could be seen that in case of 56% of households, the ICDS programme had resulted in an interest in educational aspects of the child. It can also be inferred that 72% of the households were motivated either partly or wholly, by the supplementary nutrition served at the Anganwadi which is an indication of the acceptability of the food being served.

### IV. OPINION REGARDING ICDS SERVICES

Regarding opinion about the food served at the Anganwadi, 62.3% said that the food was good and the children consumed it fully, 29% said that the food was not so good but still it was consumed fully. A small proportion, 6.9% felt that it was sometimes badly cooked or with very little oil, and therefore the children discarded the food sometimes. Unfavourable responses were largely from the less supervised anganwadi villages. None of the beneficiary families reported that diarrhoea was caused by the food to the younger children, nor that this was the reason for not to send younger children to anganwadi.

Thus overall, the acceptability of the food being served was high, and possibly, it could be improved further by ensuring better preparation and quality of food, through periodic supervision.







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#### V. CHANGES OBSERVED BY MOTHERS IN CHILDREN ATTENDING AWC

Mothers were questioned about the changes observed in children after sending them to the Anganwadis. Response was given by 60% of mothers; two thirds of those who responded to this question felt that children were healthy and well grown compared to their older children who had not attended the anganwadis; 19% felt that the children were more active and alert; and 11% felt that children developed habits of cleanliness.

Overall, all mothers concurred that ICDS was a very useful programme. A commonly made suggestion was that, if more younger children below 3 years are to benefit from the supplementary nutrition, the anganwadis should be kept open upto 4-00 or 5-00 PM to take care of the children until the mothers returned from the fields. Alternatively, they suggested that the supplementary nutrition should be prepared and served for children below 3 years at about 5-00 PM so that mothers could bring them for the feed after working in the fields.

#### VI. CHILD CARE, FEEDING AND WEANING PRACTICES

Supplementary nutrition is only one of the services expected to be provided by the AWWs. Supplementary food provided under ICDS is only a supplement, and much more participation of the family is expected for improving the child's nutritional status, through better child care, hygiene and feeding, hygienic practices. An attempt was made to study the child feeding and weaning practices, and hygienic practices and study, what if any, impact had been made on these practices.

It was found that, both in ICDS and non ICDS households (now and prior to introduction of ICDS), breast feeding had been given upto one and a half or more years of age for almost all children (except few cases interrupted due to illness of the mother). Supplementary nutrition (other than breast milk) was started for children in only 21.2% children between the ages of six months to one year. Another 37.1% of children were started supplementary foods (solids) between 1-2 years of age and 26.6% were started on supplementary food between 2-3 years of age, and 6.1% started at 3 years and above. Nine percent were weaned at less than 6 months of age due to mother's illness or death.

This pattern of weaning, and further questioning of the mothers, showed that AWWs were not emphasizing adequately on age of weaning particularly during six months to one year age. Only 30% of children totally had supplementary food introduced by one year suggesting that children suffered substantial risk of malnutrition.

Apart from this, the content of child's diet and care taken by mothers to provide both cereals and pulses was assessed. In these





When questioned about child feeding, 85% of the families reported that the child was fed with whatever was cooked for the whole family and no particular care was taken to keep unsalted dhal or prepare food specially for child's taste or needs. This situation may be resulting in pure cereal intake and little or no pulses/vegetable intake. In fact, the quantity of pulses in the diet of children under six as reported by these families was negligible. It was ascertained that at five of the nine villages, mother's meetings for nutrition education were being held from time to time, particularly to emphasize sound cooking practices and intake of green leafy vegetable particularly by young children. However, the beneficiary survey in all villages but one (Chinchodi of Deodurga which is described in the case study later), showed that the people had not changed their practices much. Keeping in view, the need to influence home feeding practices, this aspect needs further study as to how to involve the community to influence change in their practices.

Thus overall, the child nutrition practices showed, very much delayed introduction of supplementary foods for children, and imbalanced diet due to faulty feeding practices, which in turn show (i) high risk of malnutrition of children in these villages (ii) not much change in traditional feeding practices has been brought about by the AWW. This aspect needs greater emphasis so that AWW should try to influence home nutritional practices for better protein intake through simple manipulations of the normal family diet.

The influence of health education being imparted by the AWWs on dietary intake of pregnant and lactating mothers was attempted to be studied. It was found that in all 217 households, it was reported that they take the usual family diet during pregnancy and no additional items such as vegetables are taken.

During lactation however, 60.6% (74% in Raichur District and 46.2% in Gulbarga District) of households reported consuming a more nutritious diet during the first three months consisting of, combination of wheat products and rice in preference to jowar, high consumption of vegetables, ghee, dried coconut, dry dates and high consumption







tion of jaggery. Non-vegetarian families reported regular consumption of eggs and meat during lactation.

Overall, the diet intake during pregnancy was found to be deficient in folic acid, iron and calcium (when the family dietary components were assessed) and to some extent proteins. During lactation, their traditional food tended to be more nutritious. Again, in terms of dietary intake of pregnant mothers, the AWWs have greater potential to cause a change, particularly since the supplementary nutrition which is being provided for pregnant mothers can be talking point for nutrition education.

#### VIII. ADEQUACY AND POTABILITY OF WATER SUPPLY, SANITATION, AND PERSONAL HYGIENE

Adequacy of water supply and consumption of protected water influences the diarrhoeal diseases, parasitic infestations and indirectly, nutritional status of children. Similarly also, environmental sanitation and personal hygiene in terms of handwashing after defecation. Information on these practices were also collected. It was found that every village had an adequate source (adequate for all families served) of safe drinking water supply - namely tube wells or piped water supply. In all the villages visited, the SC/ST areas also had a source of safe drinking water (borewell or piped water) accessible to them. However, in spite of availability, 35.7% of families continued to use stream/river water for drinking (i.e. all persons with access to a stream preferred stream water to borewell water for drinking). In these cases, borewell water was used for bathing and washing purposes. 11.5% used water from a superficial well (draw wells only, no step wells) in spite of availability of borewell, 29% used tap water and 23% from borewell. Considering sanitation, majority of families (76%) continued to use the street area in front of the house for defecation of young children. Also, on questioning it was found that 80% of families do not use ash/soap for handwashing after defecation (adults and children).

Thus there is a need to include these practices also as a subject of health education by the AWW to the people, as a part of the total effort to improve child nutritional status.

#### IX. COVERAGE OF ELIGIBLES FOR IMMUNIZATION

Immunization coverage in the selected group of villages was found to be quite high, 81% of 417 children under six years (total) were covered with three doses of DPT, (80.6% in Gulbarga and 81.3% in Raichur district), 61.7% were covered for measles (58.3% in Gulbarga district 64.8% in Raichur district) and 72.3% for BCG (82.6% in Gulbarga and 62.7% in Raichur district). It was reported by most of the







beneficiary families as well as AWWs that the visits of ANMs and medical officers for immunization had greatly increased during the current year.

#### X. COVERAGE OF CHILDREN IN BENEFICIARY FAMILIES FOR VITAMIN A ADMINISTRATION AND PROPHYLAXIS AGAINST NUTRITIONAL ANAEMIA

It was found that of the total 326 children above two years of age, only 14 children ( i.e. tablets handed over to children's mothers) had been given iron and folic acid (100 tablets in two installments) i.e. 4% of children. The mothers reported that all tablets had been administered to the child, one per day, and none were left (to show to the research investigator - a request which was made to indirectly verify consumption of the tablets).

Vitamin A for children above one year of age was reported to have been administered to 31.5% of 368 children covered by the survey, aged more than one year and below six years of age (the proportion of children administered Vitamin A and iron and folic acid was almost identical in both districts).

#### XI. COVERAGE OF PREGNANT MOTHERS UNDER PROPHYLAXIS AGAINST NUTRITIONAL ANEMIA, AND TETANUS TOXOID

The mothers in the beneficiary families were questioned regarding provision of iron and folic acid tablets (100 tablets in two installments of fifty each) and administration of tetanus toxoid, during their current pregnancy, if more than six months pregnant, and during their last pregnancy if not currently pregnant. It was found that of 255 mothers, 24.7% had received iron and folic acid tablets during their current or last pregnancy. (This proportion was similar for both the districts - 21.9% for Gulbarga district, and 27.6% in Raichur district).

In case of tetanus toxoid, 24.3 had completed the 2nd dose (23.8% in Gulbarga and 24.\*% in Raichur). 12.4% had received only one dose of TT.

#### XII. PRACTICE OF CONTRACEPTION AND SPACING

Contraception and child spacing methods used by parents also indirectly influences child health, and is in turn influenced by parents' perception about child survival. An attempt was made to study the contraception prevalence among eligible couples in these ICDs villages.







23.5% of eligible couples were practicing family planning (23.3% in Gulbarga and 23.6% in Raichur) of which almost all were sterilization cases, and practice of spacing methods was negligible.

## XII. UTILIZATION OF MATERNITY ALLOWANCE BY THE COMMUNITY

Maternity Allowance facility is expected to be extended to agricultural landless women labourers for the first two deliveries only. An amount of Rs.300/- is to be given to the mother. Among 251 eligible couples with children below six years, seventeen, (6.7%) had received the maternity allowance. The income characteristics of the beneficiaries were as follows :

Four beneficiaries belonged to very poor socioeconomic conditions (less than Rs.2000 per annum family income at current prices of produce/wages); eight belonged to the poor category - Rs.3,000/- -- Rs.4,000/- income range, and three persons belonged to a relatively better off family (Rs.7000/- per annum) and two persons with distinctly higher family income Rs.15,000/- per annum. Most of them had received the allowance after approaching a local community leader and three had received it after registration with the ANM for antenatal case. All beneficiaries, but one, had received it only for the first or second delivery.

All beneficiaries reported that the money was helpful for better nutrition and rest during lactation. Overall, the beneficiaries of maternity allowance did belong to the poorer sections. It appeared that people felt the need to influence the process through a local community leader.

## XIV. IMPACT OF OTHER WOMEN'S DEVELOPMENT PROGRAMMES

None of the families contacted had any contact with the Income Generation Programme (IGP). A few families reported having attended the Mahila Mandals meeting for Nutrition education. In none of the selected villages, Mahila Mandals were conducting training in skills for livelihood such as tailoring or any other income generating skill.

## XV. SUMMARY OF COMMUNITY UTILIZATION AND OUTREACH OF SERVICES

To summarize, utilization of the supplementary nutrition by children particularly 3-6 year olds, was satisfactory. There is need for improvement in utilization by 1-3 year old and pregnant and lactating mothers through innovative strategies, since these groups are not utilizing the services satisfactorily. Beneficiaries were satisfied with the quality of food except in few villages which were not being frequently supervised by the anganwadi Supervisor. Nutrition practices of the villagers had not improved, especially in terms of child nutrition and nutrition of pregnant mothers. Being an essential







component of the effort to prevent childhood malnutrition, this aspect needs greater emphasis. The case of one village (Chinchodi) also showed that it is possible by the Anganwadi worker to effect major changes in nutritional practices by health education and demonstrations.)

Sanitation and hygienic practices, as well as utilization safe water supply, also were not satisfactory. All these three aspects require minor adjustment and change of attitude of the villagers, since the resources for practice of desirable sanitation, personal hygiene and safe water were found to be within the reach of all families. Again, being vital for prevention of disease and child malnutrition, these aspects require emphasis by the AWWs.

Immunization coverage among beneficiary families was good in respect of third dose of DPT and quite good in respect of BCG and measles. Immunization coverage of pregnant mothers among beneficiary families in the selected villages was not satisfactory as also prophylaxis against nutritional anemia among them. However, all mothers who were given the tablets reported that they were consuming the iron and folic acid tablets, more or less regularly.

Vitamin A administration to children was also not satisfactory. Distribution of Iron and folic acid to children as prophylaxis against nutritional anemia was almost negligible. Incidentally, these findings were coupled with an observation of relatively lesser degree of awareness and concern by the programme functionaries about these two Programmes as compared with the effort and concern regarding Immunization Programme among Anganawadi Workers. (Also, in immunization programme, it was observed that the anganawadi workers were more concerned with child immunization and not much emphasis was being laid on immunization of pregnant mothers). These findings suggest greater need for involvement of AWWs in these two Programmes also.

Maternity allowance scheme for agricultural landless labourers was also being utilized by the beneficiaries and mostly by the deserving beneficiaries, and appeared to be contributing to maternal well-being.







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APPENDIX-1

LIST OF ICDS PROJECTS (1989-90)

Sl.No.	Name of the Project	State/ Central	Year of Initiation
I.	<u>GULBARGA DIVISION</u>		
	<u>Bellary District</u>		
1)	Sandur	S	1977-78
2)	Kudligi	C	1982-83
3)	Harapanahalli	C	1983-84
4)	Hospet	C	1986-87
5)	Huvinhadagali	C	1988-89
	<u>Bidar District</u>		
6)	Basavakalyan	C	1978-79
7)	Bhalki	C	1981-82
8)	Santapur(Aurad)	C	1981-82
9)	Humnabad	C	1982-83
10)	Bidar	S	1982-83
	<u>Gulbarga District</u>		
11)	Chittapur	S	1977-78
12)	Afzalpur	C	1981-82
13)	Jewargi	S	1982-83
14)	Yadgir	S	1982-83
15)	Shorapur	C	1982-83
16)	Chincholi	C	1983-84
17)	Sedam	C	1985-86
18)	Gulbarga (U)	C	1986-87
19)	Shahpur	C	1988-89
20)	Aland	C	1988-89
	<u>Raichur District</u>		
21)	Yelburga	S	1978-79
22)	Kustagi	C	1981-82
23)	Lingsugur	C	1983-84
24)	Deodurg	C	1986-87







S1.No.	Name of the Project	State/ Central	Year of Initiation
II.	<u>BELGAUM DIVISION</u> <u>Belgaum District</u>		
25)	Raibag	C	1978-79
26)	Athani	S	1982-83
27)	Soundatti	C	1983-84
	<u>Bijapur District</u>		
28)	Jamkhandi	S	1978-79
29)	Sindhagi	C	1981-82
30)	Badami	S	1982-83
31)	Indi	C	1983-84
32)	Mudhol	C	1983-84
33)	Muddebehal	C	1988-89
	<u>Dharwad District</u>		
34)	Dharwad	S	1976-77
35)	Ranebennur	C	1981-82
36)	Hangal	S	1982-83
37)	Sirahatti	C	1982-83
38)	Hirekerur	C	1982-83
39)	Gadag	C	1983-84
40)	Mundargi	C	1983-84
41)	Ron	C	1985-86
42)	Hubli	C	1986-87
	<u>Uttar Kannada</u>		
43)	Ankola	S	1978-79
44)	Supa	S	1982-83
45)	Kumta	C	1982-83
46)	Yellapur	C	1983-84
47)	Karwar	C	1988-89
	<u>MYSORE DIVISION</u> <u>Chickmagalur District</u>		
48)	Kadur	S	1978-79
49)	Koppa	S	1982-83
50)	Mudigere	C	1982-83
51)	Sringeri	C	1988-89





Sl.No.	Name of the Project	State/ Central	Year Initiation
52)	<u>Dakshina Kannada</u>		
52)	Udipi	S	1976-77
53)	Mangalore (U)	C	1981-82
54)	Kundapur	C	1982-83
55)	Karkala	S	1982-83
56)	Belthangadi	C	1982-83
57)	Sulya	C	1983-84
58)	Puttur	C	1988-89
	<u>Hassan District</u>		
59)	Hassan	S	1978-79
60)	Channarayapatna	C	1982-83
61)	Holenarasipura	C	1983-84
62)	Belur	C	1985-86
	<u>Kodagu District</u>		
63)	Ponnampet	C	1978-79
64)	Somavarpet	S	1982-83
65)	Madakeri	C	1988-89
	<u>Mandya District</u>		
66)	Srirangapatna	S	1977-78
67)	Pandavapura	S	1982-83
68)	Nagamangala	C	1983-84
69)	Malvalli	C	1985-86
	<u>Mysore District</u>		
70)	T. Narasipur	C	1975-76
71)	Hunsur	C	1979-80
72)	Heggadadevana Kote	C	1982-83
73)	Mysore (U)	C	1983-84
74)	Kollegal	C	1983-84
75)	Gundlupet	C	1986-87
76)	Yelandur	C	1986-87







Sl.No.	Name of the Project	State/ Central	Year of Initiation
IV.	<u>BANGALORE DIVISION</u> <u>Bangalore(R) District</u>		
77)	Kanakapura	C	1978-79
78)	Nelamangala	C	1985-86
	<u>Bangalore (U) District</u>		
79)	Bangalore City (U)	C	1979-80
80)	Bangalore - S (U)	S	1979-80
81)	Anekal	S	1982-83
82)	Bangalore North	C	1988-89
	<u>Chitradurga District</u>		
83)	Davanagere	S	1977-78
84)	Holalkere	C	1981-82
85)	Hiriyur	C	1982-83
86)	Hosadurga	C	1983-84
87)	Chigalkere	C	1985-86
88)	Jagalur	C	1988-89
89)	Chitradurga	C	1988-89
	<u>Kolar District</u>		
90)	Chikkaballapur	S	1977-78
91)	Bangarpet	C	1981-82
92)	Malur	C	1982-83
93)	Mulabagil	C	1985-86
94)	Bagepalli	C	1986-87
95)	Srinivasapura	C	1988-89
96)	Chintamani	C	1988-89
	<u>Shimoga District</u>		
97)	Sorab	S	1978-79
98)	Channagiri	C	1979-80
99)	Sagar	S	1982-83
100)	Honnali	C	1983-84
101)	Bhadravati	C	1988-84







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Sl.No.	Name of the Project	State/ Central	Year of Initiation
<u>Tumkur District</u>			
102)	Pavagada	S	1978-79
103)	Kortagere	S	1982-83
104)	Kunigal	S	1982-83
105)	Madhugiri	C	1985-86
106)	Sira	C	1986-87
107)	Tumkur	C	1987-88
108)	Chikkanayakanahalli	C	1988-89



Appendix -2  
Population Coverage and Average Number of Beneficiaries Served in  
the Selected Projects  
During 1989-90

District/ Project	Taluka Population 1981	Child Beneficiaries covered (1989-90)	Mother Beneficiaries covered (1989-90)	No. of Angan- wadis	Average No. of Benefi- ciaries per AW
	Total	0-6 Yrs	No. % of taluks child popu- lation		
<b>I. Gulbarga District</b>					
1. Afzalpur	1,25,078	21,263	8,780 41.3	1,221 130	76.9
2. Chittapur	2,58,513	43,947	6,010 13.7	1,044 100	70.5
3. Sedam	1,29,434	22,003	9,089 41.3	1,031 129	78.4
<b>Total</b>	<b>5,13,025</b>	<b>87,213</b>	<b>23,879 27.4</b>	<b>3,296 359</b>	<b>75.7</b>
<b>ii. Raichur District</b>					
1. Deodurg	1,41,214	24,006	11,201 46.7	1,463 155	81.7
2. Lingsugur	2,00,128	34,021	14,570 42.8	2,220 200	83.9
<b>Total</b>	<b>3,41,342</b>	<b>58,027</b>	<b>26,771 44.4</b>	<b>3,683 355</b>	<b>83.0</b>



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Appendix - 3  
Project-wise Position of Key Staff in Gulbarga and Raichur District  
(As on November 1990)

Gulbarga District				Raichur District			
Project	C.D.P.O.	Supervisor	Anganwadi Workers	Project	C D P O	Supervisor	Anganwadi
Sanc- tioned	In Posi- tion	Sanc- tioned	In Posi- tion	Sanc- tioned	In Posi- tion	Sanc- tioned	In Posi- tion
1. Afzalpur	1	1	130	1. Lingsugur	1	1	200
2. Shorapur	1	1	222	2. Deodurg	1	1	155
3. Shahapur*	1	1	210	3. Kushtagi	1	-	137
4. Jevargi	1	2	100	4. Yelbarga	1	1	100
5. Yadgir	1	2	100				
6. Chincholi	1	2	158				
7. Sedam	1	1	129				
8. Chittapur	1	2	100				
9. Aland**	1	2	254				
10. Gulbarga (Urban)	1	4	100				
Total	10	23	1,517	Total	4	3	588

CDPO - Child Development Project Officer

\* Yet to start

\*\* Just started (1990-91)







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Appendix - 4  
Visits of Medical Officers to Anganwadis in the Selected Projects  
During 1989-90

District/ Project	No. of Anganwadis	Expected No. of visits	No. of visits made	% of Col (3) & (4)
I. GULBARGA DIST				
1. Afzalpur	130	520	232	44.6
2. Chittapur	100	400	217	54.2
3. Sedam	129	516	60	11.6
Total	359	1,436	509	35.4
II. RAICHUR DIST				
1. Deodurga	155	620	179	28.9
2. Lingsugur	200	800	304	38.0
Total	355	1,420	483	34.0
Grand Total I + II	714	2,856	992	34.7



## Appendix - 5

**Qualification of Anganwadi Workers and their place of residence in the  
Selected Projects of Gulbarga and Raichur Districts**

District/ Project	Total No. of AWWs	No. according to Qualification	No. According to Place and Residence	No. of trained Anganwadi Workers in position
	Sanc- tioned	In Posi- tion	Distance from their village of work	
			<2Km 2-4 Kms 4 Kms & above	
<b>I. GULBARGA DIST</b>				
1. Afzalpur	130	-	99	31→Breakup not available 118
2. Chittapur	100	3	18	82→ " 98
3. Sedam	129	-	94	35→ " 126
<b>Total</b>	<b>359</b>	<b>3</b>	<b>211</b>	<b>342</b>
			<b>(50.2)</b>	<b>(39.8)</b>
<b>II. RAICHUR DIST</b>				
1. Deodurga	155	1	105	35 11 136
2. Lingsugar	200	-	90	59 50 192
<b>Total II</b>	<b>355</b>	<b>1</b>	<b>195</b>	<b>94 61 328</b>
<b>Total I + II</b>	<b>710</b>	<b>4</b>	<b>390</b>	<b>122 656</b>
			<b>(55.7)</b>	<b>(26.8)</b>
			<b>(43.4)</b>	<b>(17.4)</b>



ISHA







## APPENDIX -6

**HIGHLIGHTS OF THE REVIEW OF SELECTED ANGANWADI CENTRES  
IN THE TWO DISTRICTS**

In this section, the present status of functioning of the ICDS Programme at the Anganwadi level in relation to the objectives of the ICDS, is presented. As indicated in the earlier section, in each of the Projects, one frequently supervised anganwadi and one relatively less frequently supervised anganwadi were selected. The list of village visited is indicated in chapter IV. The observations at the Anganwadis are presented.

**(i) Availability of Infrastructure**

Three of the ten anganwadis had reasonably good building : three were semi pucca (with good roof but walls and floor in poor condition); one was unsafe (with massive cracks in a recently constructed NREP building ); and in case of one Anganwadi Centre, it was being held under the trees. Utensils for cooking and serving the children were available in all the anganwadis visited. Play equipment was being made available to children in two Anganwadis (well supervised).

Registers for record maintenance were adequate in all AWCs.

**(ii) Characteristics of the Anganwadi Workers (AWW)**

Three of the ten AWWs were educated upto 7th Standard. In both the districts, the general skills and abilities as well as enthusiasm (managing the children, maintaining discipline, maintaining records, etc.) appeared to be far better in the well supervised group of anganwadis than in the infrequently supervised group. The AWWs of the infrequently supervised group, tended to concentrate mainly on the feeding programme and hardly paid attention to any other aspect of ICDS.

**iii Supervision**

The frequency of supervision by the Anganwadi supervisors in the well supervised group was about once in two months and in the poorly supervised group, it was generally once a year. However, during the last quarter, there were some visits made in recent months because of the intensive immunization drive under UIP when the Health Staff visited the villages along with the CDPO whom the supervisor accompanied. On the whole, the frequency of supervision was better in Afzalpur Project compared with the others.







#### iv. Conduct of Supplementary Nutrition Activity

Supplementary nutrition was being carried out more or less satisfactorily in almost all Anganwadis. Attendance for feeding appeared to be in tune with the number of child beneficiaries enrolled. However, in none of the five Anganwadis where feeding could be observed, the pregnant and lactating mothers came to the Anganwadi. This situation was explained by the AWWs as follows: (i) Farming Operations were in full swing during the team's visit; so all persons had gone to the fields (ii) In case of those who do not come, their children carry the food home. In this situation, it is doubtful whether the mother consumes the food meant for her.

The content of the food provided appeared to be more or less as per provision under ICDS Scheme. Indirect questions to the helper, other children and the community, confirmed that except for occasional lapses of taste due to inadequate use of oil in cooking, the quantity of food served was generally in line with the provision under SNP. Provision of cooked sprouted pulses also appeared to be routinely provided as per the provisions of 10-12 gms of dry weight per child.

In three of the ten Anganwadis, no feeding took place on the day of team's visit because of disruption in supplies. Lack of supply in case of one Anganwadi was due to transportation problem. In case of two anganwadis, it was reported to be because of CSB and oil which is to be supplied at the rate of 25 days supply for all anganwadis in the Project, had been supplied at the rate of 50 days supply for some Anganwadis which resulted in short supply for others. Feeding had been stopped for 3-10 days in these Centres. The Centres also reported such disruptions once or twice during the last six months.

However, at none of the centres, the therapeutic nutrition was being carried out for severely undernourished children. At feeding time, the extra food was just handed over to the elder child accompanying, apparently presuming that the undernourished children would be fed again later.

#### v. Manner of Feeding

Apart from the content of the food, the manner of feeding is greatly emphasized by the supervisors and the ICDS organization. The philosophy is that the feeding programme is not a food doling out programme, but also a process of acculturation of the children in taking clean hygienic meals, personal hygiene, and discipline in terms of, eating out of a plate after brief prayer, etc. Also, while dietary intake is an important aspect in improving nutritional status, practice of personal hygiene is equally important in prevention of heavy parasitic infestations, faeco-orally transmitted diarrhoeas and other gastrointestinal diseases which also influence nutritional status.







With this view, cleanliness is emphasized in the ICDS Scheme.

The difference in promotion of personal hygiene and discipline at mealtime was the most remarkable difference observed between the well supervised and infrequently supervised Anganwadis. A systematic practice of washing the plates before serving, cleaning the children's hands and feet and disciplined manner of serving appeared to be the rule in the former group. In the latter group, at three infrequently supervised AWCs, feeding was observed. In two of these Anganwadis, food was served in a slipshod, hasty manner into all sorts of plates and vessels brought by children from homes, without regard for the child's and container cleanliness or discipline, and without regard for the quantity to be served to younger children or older children.

vi) Cleanliness and Hygiene of the Children

In keeping with the promotion of hygienic practices, at all five frequently supervised Anganwadis, the children were neat and well-combed and the elder children escorting anganwadi children were seen making efforts to keep themselves and younger children clean. Whereas in the four of five infrequently supervised anganwadis, children were dirty and unkempt and no such effort by the older children was visible.

This finding showed indirectly, that Anganwadi Supervisors are rightly emphasizing on the hygienic aspects and for acculturation of hygiene in children at an early age. Also it showed that children's practices can be readily influenced for the better inspite of living in the same rural milieu.

vii. Pre-school Education

Non-formal pre-school education aims to promote healthy mental development as well as to prime the child in the discipline of learning during fixed hours, so that he/she will continue into primary school without dropout.

Pre-school component of the AWCs was found to be surprisingly good, given the rural background of the AWCs and their educational level, but only in the frequently supervised anganwadis. A disciplined, learning attitude on the part of children was observed, in children attending four of five frequently supervised anganwadis whose functioning could be observed.

In three of the five inadequately supervised anganwadis, there was almost no sign of preschool education. With difficulty, the children could be made to wait to recite the prayer before the meal on the day of visit, and they hardly showed any sign of coming to the Anganwadi for any purpose other than receiving the food.







viii. Coverage of Population for AWWs Services

a. *Coverage of 0-6 children for SNP in the selected Anganwadis*

The coverage of supplementary nutrition among the 0-6 aged children of the villages was 31% (616 of 1934 children covered). It ranged from 12.8% in Tengli ( a well supervised, well functioning Anganwadi in Chittapur taluk) to 90% of (SC) 0-6 village children, in the SC anganwadi centre of Sedam Taluk. The reasons for low coverage were (i) decrease in targetted number of children to be covered as per CDPOs instruction - this was more frequent in poorly supervised anganwadis, where, due to lower skills and interest of the AWW to manage large number, lesser utilization of services by the children with more scope for misuse of articles. Therefore, the CDPO took steps to reduce the targets and minimize misuse. (ii) Decrease in targetted number in Chittapur Project (State Sector Project) in spite of demand for services and good anganwadi performance - Tengli village.

b. *Coverage of other 0-6 children of the village for growth monitoring and health checkup*

Except in case of three anganwadi workers who were carrying out quarterly weighing of children not enrolled for SNP (all frequently supervised anganwadis), none of the other anganwadi workers had made an effort, during their entire period of service to weight all other children of the village periodically.

For the children attending the anganwadi, growth monitoring by weighing was being done regularly monthly in three of the five well supervised anganwadis. In one of the other two anganwadis, the AWW had recently returned from maternity leave, and the same weight reported during all three months. In the group of anganwadis supervised infrequently, regular monthly weighing was being done in two anganwadis; it was occassionally done in two of the anganwadis, and in one anganwadi records were not available to verify the weighing of children. However, attention for immunization coverage was equally given to enrolled children as well as those not enrolled at the AWC.

c. *Coverage of pregnant and Lactating Mothers*

This was uniformly limited to about five pregnant and five lactating mothers of the village in all anganwadis. However, in more of the anganwadi centres where feeding was observed, none of the mothers showed up. The food was reported to be sent to their homes through the children.





ix. Accuracy of Weighing:

Accuracy of weighing and grading of the child by the AWW was found to be largely satisfactory. This was checked by comparing the weight of randomly selected five to six children, recorded by the study team and weight recorded in the growth chart by the AWW in the current month. Inaccuracy and new dubious weights recorded by AWWs was found only in two infrequently supervised anganwadis.

x. Home visit for Health and Nutrition Education

Home visiting on a regular basis could be confirmed from the records (diary) of four out of five frequently supervised anganwadis and from the homes visited in case of one. In the five frequently supervised anganwadis, two AWWs reported that they visited occasionally the homes, the other three reported daily home visits but in none of the five this could be verified.

xi. Liaison for Health Services Immunization:

All the AWWs except two infrequently supervised were aware of and concerned with immunization of all children in the village. Two major constraints were reported by the AWWs to achieve 100% coverage of immunization. Frequently the Health Worker female/MO did not turn up on the dates fixed up, which resulted in loss of credibility of the worker. However, this situation was reported to have improved this year. All but two villages reported monthly visits by health staff for the last three months for immunization camps. The second major constraint was lack of community acceptability for immunization in certain pockets. This was reported particularly by the AWWs of the infrequently supervised anganwadis. This suggests that in the frequently supervised group, the AWWs during the home visit and other community contacts are able to convince the population about the benefits of immunization. Records of most AWCs could not provide the exact figures of completely immunized children. However six of the AWWs reported that most of the children in the village were immunized fully. The remaining four (all infrequently supervised) were not aware of the immunization status as they did not work with the ANM during the immunization.

xii) Vitamin-A Administration and Prophylaxis against Nutritional Anemia

Under the ICDS Scheme, coverage for Vitamin A and anemia prophylaxis is not required to be recorded by the AWWs. Four of the ten AWWs were not aware whether these activities were being carried out in these villages. Two were aware of, concerned about and participating for Vitamin A administration and anemia prophylaxis. However, in none of the villages Vitamin A administration had been done systematically for children whether those attending the anganwadi or otherwise. Four







out of five AWWs in the group of infrequently supervised and two frequently supervised anganwadi workers reported that iron and folic acid tablets are required only for 'weak' children.

xiii Visits of Medical Officers

Except in case of the two anganwadi centres which were located in PHC headquarters village, in case of all the others visit of MOs were rare: One AWC started in 1984 reported no visit of MO since 1984; one AWC reported no visit to MO since last three years, and another AWC reported no visits since one and half years. The other five reported that until this year, visit of MO was once in a year or never, but this year one or two visits had been made during last three months in connection with immunization camp (UIP immunization drive).

xiv. Prevalence of Paralytic polio in Under-six children

This information on prevalence of paralytic polio in the under six children of the village was collected. Eleven cases of paralytic polio were reported to be prevalent by the AWWs in 1934 children or a prevalence of about 5.6/1000 children under six years of age.

xv. Diarrhoea Prevalence

Diarrhoea was not reported to be significant problem by any of the AWCs. All except one reported that an average of 2-3 children attending the AWC suffered from an episode of diarrhoea during one month.

xvi. Other major health problems:

In one village, Chandapur of Sedam taluk, very high prevalence of elephantiasis was reported with high morbidity rates. It was reported that about 100 of the 1433 village population suffered from this problem. Elephantiasis was very uncommon in this village 8 years ago when there was no irrigation. Irrigation from the small lake and nearby stream eight years ago was followed by high prevalence of elephantiasis. However, no attempt had been made by the PHC concerned to assess the problem, control or provide relief to the villagers, on public health grounds.







## APPENDIX - 7

REPORTED NUTRITIONAL STATUS OF CHILDREN IN THE ICDS  
PROJECTS OF KARNATAKA

1. The data on nutritional status was available since 1986-87 upto 1989-90. Baseline survey data from the Projects was not available. The data on the Projects at State level was first scrutinized for reliability, and also compared with the available annual survey data of the ICDS Biostatistics Cell of AIIMS, which provide technical support and monitoring services to the ICDS Programme at a National level. The reliability of Project reports furnished to the State level was judged based on consistency of proportion of malnutrition reported from year to year, or consistency of trends of moderate and severe malnutrition from year to year in the Project. Since these proportions are based on numbers of malnourished reported, which in turn is based on compilation from 20-60 anganwadis in each PHC area, and reports of several PHCs are compiled into Project figures at State level, it was inferred that consistency in reported percentages of malnourished children from year to year (over the four years) was a fair indication of reliability. Based on this indicator and comparison with annual survey reports the following tentative conclusions could be drawn regarding changes in nutritional status as reported by the PHCs in the ICDS Projects.

It was inferred that from 73 of 97 projects for which data was available, the workers appeared to be providing fairly reliable data. Nine of the 24 projects for which data was considered unreliable were in Gulbarga division and five were from Gulbarga district.

General Observations on Reported Nutritional Status in the State

The inference on changes in nutritional status are based on the data from 72 projects all over the State (Table not presented) and are as follows:

i) Most of the Projects which showed prevalence of moderate malnutrition in the range of around 15% or 20% in 1986-87 tended to show a clear declining trend during 86-87, 89-90. The decline was more marked in those showing 20-30% moderate malnutrition than those showing around 15% of children with moderate malnutrition.

This suggests that in most taluks, it is not very difficult to bring down the prevalence from high levels upto a certain average level. This proportion of malnutrition is possibly related to food scarcity. Beyond this the prevalence is probably related to other factors (sociocultural and child care practices) which may be more difficult to impact and this is possibly the reason why in most taluks reported figures of around 10-12% tend to remain the same range over many years.







ii) Comparison of research data of ICDS Annual Survey 1987 with corresponding reported figures from the Projects for 5 ICDS taluks showed that moderate malnutrition figures furnished by the Projects are more or less correct (+2 - 8% variation), but severe malnutrition is grossly under-reported in routine reports. This was evident from the Karnataka Annual Survey 1987 report of Malur, Nagamangala and Deodurg. In case of one Project, it did not correspond but this Project was showing bizarre figures from year to year and was already classified as unreliable from the Annual State Reports.

iii) Proportion of children with severe malnutrition has shown a clear declining trend in all but few taluks.

iv) The absolute prevalence rates of severe malnutrition (SMN) are probably much higher than what is reported if one considers the Annual Survey data which is available on few taluks, and also the State wide prevalence figures indicated by research data.

Possibly, wide discrepancy between reported figures of SMN and actual may be because of many factors:

Anganwadi workers have only one objective tool to assess the child weight; unless clinical assessment by MO is also supplemented at least three monthly, a child with higher weight due to oedema of PEM may come in the moderate group if the AWW cannot assess oedema, hair, skin, and other signs of malnutrition. Also, she is often unable to assess the weight anomalies due to restlessness of the child while weighing in the Salter scale. Another factor would be the reluctance of the Anganwadi workers to report severe grades of malnutrition, which would be perceived by higher-ups as failure of the Anganwadi worker to prevent or tackle the problem. Thus, one may expect that underreporting of severe cases will be much more common. An evaluation study conducted during 1985-86 by the Evaluation division of Institutional Finance and Statistics division of Karnataka Government did bear out the former point. It was observed that none of the eight Anganwadis surveyed in that study had a visit of MO during the last one year even though the reports by the PHC showed high achievement of targetted Anganwadi visits by MOs. In view of these factors, possibly there is a good deal of under reporting of severe malnutrition. The higher the reported rates of moderate malnutrition, one should suspect very high rates of missed SMN.

v) Some information on the functioning and impact of the ICDS Project can still be inferred from the trends of severe undernutrition, and together with prevalence of MMN, it would give an indication, whether the situation is improving over the years or deteriorating or static. Also, a comparison with recently started Projects in incomparable areas (if the figures appear reliable) would give an indication of the relative functioning of the ICDS Projects in a District.







Since accuracy of recording, skills and ability of the AWW to accurately assess the nutrition may be limited, particularly with nil or infrequent supervision by the supervisors and MOs, it has been considered appropriate to take trends into consideration rather than absolute prevalence, for indirectly assessing the status of implementation and impact of the Programme in the Divisions.

The difference in prevalence of malnutrition in the different taluks during years 1986-87 to 1989-90 appeared to be in line with the general developmental level of that taluk. Backward taluk in fairly advanced districts, such as Belthangadi and Sullia in D.K. continued to show higher levels of malnutrition whereas the developed taluks like Coondapur, Karkala and Udipi showed considerably lower levels. Mysore Division which ranks first with regard to almost all the Health and Family Welfare Programmes, including Family Planning appears to be leading in ICDS also, in the sense that maximum proportion of projects are furnishing consistent figures from year to year, and maximum proportion are showing declining trends even in taluks with initially high levels of malnutrition. In Gulbarga Division a backward division, which has always ranked lowest in the health and family welfare programmes, appeared to have made relatively less progress in ICDS Programmes also. Reporting on nutritional status from many Projects was poor; of the thirteen Projects which appeared to be reporting reasonably reliable figures, only in four Projects, a clear declining trend of moderate malnutrition could be observed; large number of ICDS taluks of Gulbarga, continued to show high levels of moderate malnutrition (15-20% or more) in spite of many years of operation of ICDS, as compared with similar Projects of other divisions. Even within Gulbarga division, the relatively advanced taluks showed better situation, such as, in Raichur, for example, the relatively better off taluk Lingsugur, was showing better situation in almost all years as compared with Kushtagi and Deodurg.





## HOUSEHOLD INFORMATION SCHEDULE



### I. Identification and Socioeconomic particulars

1. Name of the Village:

Household No.

2. Head of the Household:  
and his Fathers name

3. Occupation of Family Members:

Normally

During Summer Season/drought

i)

ii)

iii)

4. Annual Income of family from all sources:

5. Religion:

6. Caste (whether SC/ST):

7. Type of house : Kutcha (with thatched or broken tiled roof)  
Pucca (with sound tiled /RCC roof)  
Pucca but dilapidated

8. Socioeconomic level: very poor/poor/middle income/rich

9. Source of water including summer: Tube well/superficial well/tap/step well/pond  
type distance

1. Drinking

2. Washing

10. Approximate quantity drawn during the day for drinking:

Approximate quantity of water drawn during the day for washing purpose:  
(average size bucket holds 12-14 liters)

11. Sanitation and Toilet habits:

a. Place of defecation: adults —  
Young children —

b. Hand washing: Water only —  
Water Ash/soap—

c. Handwashing after cleaning up child/infant on defecation:  
i) Water only:  
ii) Water and ash

### II. Demographic Information:

1. Household size:

2. Number of ECs in the household

3. Number of children: i) EC I : Male  
Female

NUT-100

01794

COMMUNITY HEALTH CELL  
326, V Main, I Block  
Koramangala  
Bangalore-560034  
India

ii) EC II : Total:  
Male :  
Female:

4. Whether practising family planning presently and method:

i) EC - I : Yes/No Method:  
ii) EC - II : Yes/No Method:

5. Number of children in the age group 0-6 years:

### III. Details of availing Anganawadi services

#### 1. Children

No	Name	Age	Sex	Whether taking supp. Nut at Anganawadi & how often	Immunization status (DPTP Measles BCG)	What are the changes mother sees after sending to Anganawadi
1						
2						
3						
4						
5						
6						

2. a) Number of women in household:

i) Pregnant (how many months):

ii) Lactating

b) Whether availing supplementary nutrition at Anganawadi? If so how often? Whether receiving antenatal checkup? Who advised her? How often does she get check/up? TT immunization? At which months? Did she get Iron and Folic acid tablets?

### IV. General Health Status

1. What are the health problems in the household experienced during the last six months? (Describe nature of the health problem, who was affected, duration of illness, treatment taken from whom, what treatment (pills, injections, massage, other treatment)? Especially enquiry regarding respiratory infections, diarrhoea, chest complaint, etc.)



2. Any chronic health problem or handicap experienced by any member of the household? (Describe in detail)

3. Clinical findings and tentative diagnosis:

#### V. Nutritional Intake

a. Collect information on the major cereals, pulses, vegetables, oil, milk, non-vegetation items, (quantitatively) used for cooking on an average per day during post harvest months and lean season:

b. Dietary intake of women:

- i) Non-pregnant
- ii) Pregnant State
- iii) Lactating: Early months:  
After three months:

c. Nutritional Intake of Children

(i) Age upto which breastfeeding done for each child:

- |     |     |
|-----|-----|
| (a) | (d) |
| (b) | (c) |
| (c) | (f) |

(ii) Age of Introduction of supplementary food for each child: \_\_\_\_\_

(iii) Nature of food started with \_\_\_\_\_

(iv) Quantity and items of food given during a day to children:

	Items		Quantity		Remarks why not other foods
	In general	Female Children	In general	Female Child	
1 Year					
1-2 Years					
2-6 Years					

(v) Whether the food is from the family cooking pot or separately cooked with less spices/any other modification?

(vi) Whether the mother feels that children below 6 years refuse certain items of food due to spices/taste considerations? Upto what age she has difficulty in feeding children due to this problem? Indirect questions as to Does she take any special care to cook for male children as compared with females?

(vii) Has she been educated of the type and quantity of foods to be fed to children/take herself during pregnancy and lactation? If so when did she learn? From Whom? Has she been able to practice some of the ideas given? If yes, what changes has she made? If no, or only partly practising, why does she not practice the other aspects taught?

(viii) Since how many years she has been sending her children to the anganawadi? Details regarding each child at what age and how long sent to anganawadi? What are the reasons to send them? Food only? Nutritious Food? To babysit while she works?

(ix) What work does she do during the day (household work/work for wages/help on family land/business without wages)

(x) Has she herself availed supplementary nutrition at Anganawadi during pregnancy/lactation? If no, why not? If yeas, during which of her pregnancies did she avail and how long each time?

(xi) What is her opinion regarding Anganawadi activities? Feeding programme? To herself and children? regarding timing, suitability of food, taste and acceptability, reasons why she and her children have not availed (if they have not availed)? Whether they go regularly? How many days of the week do they go? On how many days the week do they consume all the food provided? Does she/children discard food sometimes due to excess or unpalatability? How often? How much? Whether Anganawadi regularly provides food throughout the year? Any short comings?

(xii) What are the changes the mother has observed made since she started going/sending children to Anganawadi

	Changes observed/change in Practices
1. General appearance of Children	
2. Weight & Height (compared with her expectation for the age or with her older children who did not go to Anganawadi)	



- |  |  |
|--|--|
| <p>3. <b>Diarrhoeal Episodes:</b></p> <ul style="list-style-type: none"> <li>a) Number/month How much reduction</li> <li>b) Duration of diarrhoea</li> <li>c) Severity of illness</li> <li>d) Recovery</li> <li>e) ORT</li> </ul> <p>4. Breast feeding practices &amp; Duration (any change)</p> <p>5. Weaning and infant feeding (frequency, quantity and content of food)</p> <p>6. Cooking practice and Family diet</p> <p>7. Diet during pregnancy and lactation</p> <p>8. Feeding children 1-6 years</p> <p>9. Immunization of self and child</p> <p>10. Antenatal checkup and post natal care</p> <p>11. Delivery-nature of birth attendant preferred and utilized, Doctor/ANM/ Trained dai/any body else</p> <p>12. Personal hygiene in hand washing after defection/ cleaning up infant/child</p> <p>13. Disposal of infant/child excreta</p> <p>14. Cleanliness of home and surroundings</p> <p>15. General Health of self and family</p> |  |
|--|--|
- xiv) Have her children 1-5 received Vit A drops and iron and folic acid? How often, how much during which month? Is she aware that these have to be given? If not taken, why not taken?
- (xv) Does she participate in Mahila mandal activity? Does she know of any such organization? What do they do? How did she benefit from that? Does she feel it is beneficial and must continue? Does she know if other families/ women benefitted from Mahila mandals? How?

xvi) Did she receive maternity allowance after her delivery? If so what no. of deliveries thus assisted and serial no. of the children (live)? How much did she receive? From whom? Did she have to make any effort to get the benefit? What effort? (getting opinion leader/community leader, influencing ANMS-how or as a routine when she registered for ANC & delivery) Does she know of any other women in her village who got it? Details.

xvii) What was done with the money? Did she spend it on nutritious food for herself/family? Did husband/head of family receive it? Was it spent on repaying debts/alcohol, Social functions/social obligations (marriage of relative, etc) Does she feel that during this post delivery period she had better food in quality and quantity, and better strength than when she did not get the allowance. Any observations/experiences of neighbours/others who received? Any opinion regarding this benefit?

xviii) Has she received help/training/guidance/for improving her income family income/agricultural practices from any source? If yes, nature of assistance, agency, and quantum of financial assistance, details, result of the assistance what improvement occurred? Does she know of any other woman or family who had such assistance/training? details? opinion?



















